GRANT
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IN
HEALTH

PUTTING PEOPLE FIRST

Keynote Addresses from the Annual Meeting on Health Philanthropy

FEBRUARY 2004

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Foreword

This report features plenary speeches delivered at Grantmakers In Health's 2004 Annual Meeting on Health Philanthropy, *Putting People First*, held February 25-27, 2004 in Hollywood, Florida. The meeting explored how efforts to deliver health care and improve health have strayed from their fundamental purpose of serving patients, families, and communities and identified opportunities for grantmakers to support system and institutional redesign, policy reforms, and cultural and behavioral changes that truly put people first. In addition to the plenaries, breakout sessions and site visits offered grantmakers an opportunity to engage leading health experts, community leaders, and grantmaking colleagues in provocative, insightful discussions on important issues related to putting people first.

Pedro Jose Greer shared his personal stories as a physician to bring clarity to the urgent needs of underserved populations in Miami, Florida.

Lauren LeRoy, president and CEO of Grantmakers In Health, charged health grantmakers to move forward with rigor, passion, commitment, and leadership in efforts to transform the health system to put people first.

Harvey Fineberg, president of the Institute of Medicine, described the six attributes of an ideal health system: population perspective, public health and prevention are integral components, universal access, patient centered, evidence based, and quality-driven, and offered 10 strategies to approach 21st century health care.

King Davis, executive director of the Hogg Foundation for Mental Health, shared with us more than 50 recommendations for health grantmakers when setting priorities and making funding decisions related to mental health.

Marion Standish from The California Endowment, Mary Story of the University of Minnesota, Jerome Williams from the University of Texas at Austin, and Margo Wootan of the Center for Science in the Public Interest drove home the health consequences of advertising and marketing high-calorie, high-sugar, low-nutrition foods for the nation's children.

David Gould, in his acceptance speech for the Terrance Keenan Leadership Award in Health Philanthropy, encouraged grantmakers to seek out, challenge, and support champions for change working in the trenches.

We appreciate these and all the other speakers at the meeting who shared new information, insights, and strategies to help grantmakers improve the nation's health.

About GIH

The mission of Grantmakers In Health (GIH) is to help grantmakers improve the nation's health. Working with over 200 organizations, large and small, both locally focused and national in scope, GIH seeks to build the knowledge and skills of health funders, strengthen organizational effectiveness, and connect grantmakers with peers and potential partners. We help funders learn about contemporary health issues, the implications of changes in the health sector and health policy, and how grantmakers can make a difference. Meetings, publications, networking, and technical assistance are among vehicles we offer for funders to learn from GIH and from each other.

As the professional home for health grantmakers, our work covers the territory. We look at health issues through a philanthropic lens, sorting out what works for health funders of different missions, sizes, and approaches to grantmaking. We take on the operational issues with which many funders struggle (such as governance, communications, evaluation, and relationships with grantees) in ways that are meaningful to those working in the health field.

How do we do it? We generate and disseminate information through meetings, publications, and an on-line presence; provide training and technical assistance; offer strategic advice on programmatic and operational issues; and conduct systematic studies of the field.

EXPERTISE ON HEALTH ISSUES

GIH's Resource Center on Health Philanthropy is a source of expert knowledge on different subject areas within health and effective grantmaking strategies. The Resource Center maintains descriptive data about foundations and corporate giving programs funding in health and their grants and initiatives, and synthesizes lessons learned from their work.

Keeping track of the field requires expert staff and powerful tools. After all, health grantmakers work on every issue under the umbrella of health, from improving access to shoring up the public health infrastructure to building healthier communities. With strong experience in public health, health policy, and community work, GIH's staff identify trends and emerging issues, develop programs, and provide advice. The Resource Center's database is available on-line on a password-protected basis to GIH Funding Partners (health grantmaking organizations that provide annual financial support to the organization). The database contains information on thousands of grants and initiatives made by over 300 foundations and corporate giving programs and can be searched by organizational characteristics (such as tax-exempt status, geographic focus, or assets), health programming areas (such as access, health promotion, mental health, and quality), targeted populations, and type of funding (such as direct service delivery, research, capacity building, or advocacy).

ADVICE ON FOUNDATION OPERATIONS

GIH also focuses on operational issues confronting health grantmakers through the work of its Support Center for Health Foundations. The Support Center tackles both fundamental and complex issues, such as designing an effective grants program or assessing organizational performance, and puts these in a context that makes sense for those funding in health. We work with foundations just getting started (including dozens of foundations formed as a result of the conversion of nonprofit hospitals and health systems) and with more established organizations. The Support Center's work includes:

- The Art & Science of Health Grantmaking, an annual two-day meeting offering introductory and advanced courses on board development, grantmaking, evaluation, communications, and finance and investments;
- sessions focusing on operational issues at the GIH Annual Meeting on Health Philanthropy;
- individualized technical assistance for health funders; and
- a frequently asked questions feature on the GIH Web site.

CONNECTING HEALTH FUNDERS

When health grantmakers get together, the learning and energy are palpable. GIH creates opportunities to connect colleagues to each other and with those in other fields whose work has important implications for health. GIH meetings, including the Annual Meeting on Health Philanthropy, the Fall Forum (when we focus on policy issues), and Issue Dialogues (intensive one-day meetings on a single health topic), are designed for health funders to learn more about their colleagues' work; talk openly about shared issues; and tap into the knowledge of experts from research, policy, and practice. Our audioconference series offer the chance for smaller groups of grantmakers working on issues of mutual interest, such as overweight and obesity, racial and ethnic disparities, patient safety, or public policy, to meet with colleagues regularly without having to leave their offices.

FOSTERING PARTNERSHIPS

The many determinants of health status and the complexity of communities and health care delivery systems temper health grantmakers' expectations about going it alone. Collaboration with others is essential to lasting health improvements. Although successful collaborations can't be forced, GIH works to facilitate those relationships where we see mutual interest. We bring together national funders with those working at the state and local levels, work with other affinity groups within philanthropy, and help connect grantmakers to organizations that can help further their goals.

GIH places a high priority on bridging the worlds of health philanthropy and health policy. Our policy portfolio includes efforts to help grantmakers understand the importance of public policy to their work and the roles they can play in informing and shaping policy. We also work to help policymakers become more aware of the contributions made by health philanthropy. And when there is synergy, we work to strengthen collaborative

Diversity Statement

GIH is committed to promoting diversity and cultural competency in its programming, personnel and employment practices, and governance. It views diversity as a fundamental element of social justice and integral to its mission of helping grantmakers improve the nation's health. Diverse voices and viewpoints deepen our understanding of differences in health outcomes and health care delivery, and strengthen our ability to fashion just solutions. GIH uses the term, diversity, broadly to encompass differences in the attributes of both individuals (such as race, ethnicity, age, gender, sexual orientation, physical ability, religion, and socioeconomic status) and organizations (foundations and giving programs of differing sizes, missions, geographic locations, and approaches to grantmaking).

relationships between philanthropy and government. GIH has established cooperative relationships, for example, with a number of federal agencies, including the Agency for Healthcare Research and Quality and the Centers for Disease Control and Prevention.

EDUCATING AND INFORMING THE FIELD

An aggressive publications effort helps GIH reach a large number of grantmakers and provide resources that are available when funders need them. Our products include both in-depth reports and quick reads. *Issue Briefs* delve into a single health topic, providing the most recent data, sketching out opportunities for funders, and offering examples of how grantmakers are putting ideas into action. The *GIH Bulletin*, a newsletter published 22 times each year, keeps funders up to date on new grants, studies, and people. Periodic feature articles include *Grantmaker Focus* (a profile of one of the many foundations and corporate giving programs working in health), *Views from the Field* (written by health funders about their experiences), and *Issue Focus* (quick insightful analyses of challenging health issues).

GIH's Web site, www.gih.org, is a one-stop information resource for health grantmakers and those interested in the field. The site includes all of GIH's publications; the Resource Center database (available only to GIH Funding Partners); and the Support Center's frequently asked questions. Key health issue pages on access, aging, children/youth, disparities, health promotion, mental health, public health, and quality provide grantmakers with quick access to new studies, relevant GIH publications, information on upcoming and past audioconferences, and the work of their peers.

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Welcome

Pedro Jose Greer, Jr., M.D., University of Miami and Community Voices-Miami

My name is Pedro Jose Greer. I was born here in Miami. The beauty of Miami, as many would say, is our proximity to America. The truth is—and I want to say it—Miami is more American than any other city in this country. I will tell you why. We are a city that brings people from everywhere and makes it work. Sixty percent of our population was not born in this country. More than half of the population speaks a second language at home. We are a bit provincial, but we are fun. We are a city of E's—Elian, embargo, exile, and elections. We are actually a pretty exciting city. We are number one in baseball. We are number one in poverty. We have the number one wealthiest neighborhood in the country, which is Fisher Island, where you take your boat for a ride and you get to an island and you visit people.

We also are number one in poverty. In the 1990 Census we were not number one; we were number four, which is good because we worked really hard and we became number one. That is because the other three cities ahead of us decided to set policies that would take care of their populations. This is one of the issues that I think foundations have to be very involved with because you all have got the money, folks. You get to go to the cocktail parties and talk to the politicians. The politicians are the ones who change things.

I went to the University of Florida. Actually, I played football there. Let me tell you a little story. I played on the worst high school football team in the history of mankind. We won one game, my senior year homecoming game. But I went off to play at the University of Florida. Now, my name is Pedro Jose Greer, P.J. Greer. When I went to play ball at Florida, it was the second year that the Southeastern Conference was desegregated. Greer is a very common southern black name. So whoever assigned rooms assumed that I was black. And although there was no segregation, there was separation. Dorms were somewhat separate, and I was put in the black half of the dorms. I got there and my roommate, Charlie Horse Johnson, who was I think possibly the largest human being ever, opened the door, and he just looked at me, and he said, “I thought you'd be black.”

Well, I weighed my options. He was huge. So I looked at him and I said, “It's worse than you think.” I said, “I'm Cuban.” I said, “We look like them, but we dance like you.”

I learned two really important lessons at that point. When somebody is really, really big, just for self-preservation purposes, become their friend. And, number two, in this world when we look at what we have in common, instead of what are our differences, we make much more progress.

In this world when we look at what we have in common, instead of what are our differences, we make much more progress.

I am lucky, because my father is a physician, and I was allowed education—private education—as my children are allowed. My father was not allowed that. My father is the first one in our family to finish high school, much less go to college or to medical school.

He is 76 years old, and he works every single day except Fridays. And people say, "He's 76. God bless him. He should have Fridays off." The truth is, he has never worked Fridays. Maybe that is why he is still working at 76. He tells me that a doctor never retires, and he has proven it. But he also has proven the importance of education. When one member of a family breaks out and becomes educated, it is not just for their benefit or their immediate family's, but for the subsequent families.

Talk about being in the city that is number one in poverty. I am sure you have read about Miami. Look at Miami. Look at the policies. You go from number four to number one in poverty. There is no excuse. There is no reason why that happens except for pure lack of vision or policy. I am a little tired with our politicians. I am a little tired with corruption. I am a little tired because I have had my experiences in Washington in both the old Bush Administration and Clinton Administration. They have increased the number of uninsured by, what, 35 percent? Of all the uninsured in this country, 66 percent to 75 percent are employed full-time.

Where does the ethical and moral responsibility lie? Does it lie in the hands of government that does not set the policies or does not enforce the policies they do set? Or with the chief executive officers and boards who think that the margin is more important than people's lives? These are real questions to ask, because people go without. And those who have must learn that it is not them versus us.

I am one of them, with an education. Now that is a scary thought. And I am also a storyteller. I am Cuban-Irish. I am from one poor, small, corrupt Catholic island to another. Island people tell stories. That is what we do. We tell stories. We tell stories of our experiences. We tell stories of other people's experiences, but mostly of our interactions.

I am a writer. That is what I do, and that is how I am going to speak to you today, because I can speak better not about the quantitative aspects of policy, but about what happens when these quantitative aspects of policies are not passed through.

When we sit in these lovely boardrooms and we make decisions about people, we are not the ones who sit there and look at someone in the eye and say, "Oh, I'm really sorry. We're closed." Or, "Oh, what? You're 15 years old, you're pregnant, and you're on crack? It's 10:00 at night. Come back in the morning at 9:00. We'll be open then."

No, we do not have to make those decisions, because those decisions are made by the people who sit there and work on the front lines every day. I will tell you the truth, particularly of the social workers. We physicians, we are fun. Social workers, they are the heroes. They are the ones who make the changes, because the infrastructure is being lost.

What kind of opportunities can we offer these children in the future when we do not care for the people now? 125,000 on the roll—do you realize that in 1999, in Dade County alone, there were 100,000 children without health insurance? 100,000 children.

Do you realize that in 1999, before the big economic crash, if you took away the Medicare population, one in every three people in Dade County was uninsured. If you added the Medicare population, it brought it down to 25 percent—one in four.

So what kind of justification does a society have to allow people to suffer? What kind of society do we live in, folks? I love being an American. There is no greater society I love to live in. But I live in a society in which I feel, in medicine, we will not let you die, but we do not really care if you suffer.

If you come in bleeding, you come in with a myocardial infarction, you come in with any problem into an emergency room, we will resolve your problem, and then we will discharge you. Then you will be back, and then we will discharge you, and then you will be back.

Let me just give you an example of the complication. A kid in school has bronchial spasms and an asthma attack, and gets taken to the emergency room. Mom is working. She has to leave work to go meet him at the emergency room. She has no insurance, because she cannot work full-time, or if she does, the company is not going to give her the insurance. And the kid gets seen by an emergency room doctor, who does not evaluate the child or their home, who does not look for allergens that could be causing the bronchial spasm, and it is a repeat visit. The family cannot make money, the kid cannot be competitive in school, the mother cannot maintain a job. Oh, but let us try putting these families in the HMO system, see how that works. Well, the only ones it will work out well for, especially in the states of Florida and Tennessee, are the HMO chief executive officers and the captains of industry who buy their homes here in Florida because of tax shelters. I mean, where are all of the Enron officials, the ones who have not been busted? Look at their homes, look at the mansions of these individuals. What right do we have to take public dollars and allow those who do not have to suffer?

I have no problem making money. But I do have a problem when you are in an organization and when you are on the front line and you have no support. One of the things you foundations need to do is make sure that the institutions that receive your monies and deliver care have two, and only two, real responsibilities—first and foremost, to those who they serve, and, almost as important, to those who support them to serve. Grantmaking procedures should be transparent. They should be wide open. You should require that these two responsibilities are met because there are not enough dollars going around in the right areas to make things work. You had better make sure they are working well. And most of these institutions that are doing it are doing it from the heart, so sometimes they just need technical experience on how to deal with things. Work with them, they have the passion. They have the desire.

One of the things you foundations need to do is make sure that the institutions that receive your monies and deliver care have two, and only two, real responsibilities—first and foremost, to those who they serve, and, almost as important, to those who support them to serve.

These are individuals who could be sitting in the same boardrooms that I sit in. These are individuals who have chosen, instead of money, to devote their lives to helping others. These are individuals we need to support.

Money counts; we all know that. But if somebody does not break through, look at all of the talent we have lost in this country, in this nation, in this world. Look at all of the children who suffer, all of the adults who do not have, because we make policies or we become a little too greedy or perhaps a little too corrupt in our society. There are things that are right, and there are things that are wrong. And there are people who suffer the consequences when we do not follow what is right. And, you know, if you want me to talk to you about statistics and health here, I can do that. But let us not do that, because statistics are numbers. They are not people.

In Miami, more than 50 percent of the population is Hispanic. But you know what? We are a pretty diverse group, too, folks. We are extremely diverse. We are black, we are white, we are African. You name it. And we are proud of where we are from, just as we are so incredibly proud to be Americans. And the thing that makes us different is the fact that I can stand up here and talk, you can listen, you can agree, you can disagree, but we all get together and say there is a problem. “Let’s fix it, let’s make it work,” we say, because each and every person in this room is one of the ones who has it.

You have been blessed. You are lucky. You have been placed in a point in society where you make decisions for other people’s lives, for other people’s well-being. Do you understand the gravity of that responsibility? Do you understand that a mother or a child might not have anything if it were not for you? And do you also realize that if on one of those days you are in a bad mood, and you just make a decision that does not make any sense, somebody could suffer from it, too? So do not take your roles as working at foundations or being on boards lightly. You hire your CEO, he or she forms a team, you support the team with your policies.

The truth is you have that responsibility. When was the last time you rolled up your sleeves and you went to one of the areas that you fund, sat down and talked to somebody as an equal? Have you ever tried that? Oh, well, let’s see. I have got doctoral degrees and postdoctoral degrees, so I must be better. I look at it the other way. I do not think I could survive a day under a bridge or being undocumented. Hell, I could not make it without education. I was too stupid.

We are a society that has enough resources, and there is no reason we cannot get it done. The reason that we do a lot of the things we do, the reason we started clinics, is there is no system we cannot fight and beat and defend for those who need it.

We first started our homeless clinic 20 years ago—and I am going to tell you the story why. Let me start off with a quote from *The Brothers Karamazov.* It says, “For every hour and every moment, thousands of men leave life on this earth and their souls appear before God. And how many of them depart in solitude unknown, sad, dejected, that no one mourns for them or even knows whether they had lived or not?”

Is it statistics, or are we going to look at people in their face and treat them as equals as we should, both under our law of this country and under all of the faiths that we live under? It is not other people, folks. It is one world, one nation. That is it. We are just the lucky ones. And if we are the lucky ones, we carry a big responsibility to let everybody else be as lucky as we are.

Our faiths tell us the same thing. When I was young, one of the most devastating things in my life happened to me. I was in medical school, my sister was a freshman at my alma mater, University of Florida. She called me and told me she wanted to spend her 18th birthday with me. Well, she never made it. She died two weeks before her birthday in a car accident coming down to spend her birthday with me.

Now, let me tell you what it is like to be 22 years old in medical school, ready to save the world, and your sister dies. And you are from an immigrant family. I am the natural-born immigrant, and my sister, who was younger, was born here, too. But my older sister and everybody else was not born in this country. Being the only boy growing up in the ‘60s, you had the responsibility for the girls; that was just the way it was. You also lived in this exile immigrant home, the TV is in English, and the civil rights movement is going on at the same time. The world is changing, not just around you but within your own family, because you cannot relate to any of the stories your parents tell you, because they grew up somewhere else. And you have your sisters. My sister had all those advantages. She had the life, she was studying to be in special education. I mean, how altruistic can you get? And then she dies. You want to question faith, you want to question God, you want to question everything. Try that, folks. Try being a young man or woman with the passion and the belief that you are going to change the world, and have one of the persons closest to you in your life go, just like that.

After much anger, after much everything, I realized that if God lets you be born, he lets you die. It is what you do in between. I made a promise to God that if I ever became a doctor, I would never want to let anybody suffer or die alone. Well, there is a problem when you make a promise to God. Where are you going to hide? I found City Hall, because even God does not go there. We know that by the policies that they have been making the last decade, so I found a refuge. But it gets quite boring in there. It is not like there are deep conversations. And so we started a clinic for the homeless. We were young and we were stupid. We were stupid enough not to know that education was not the answer to resolving a problem.

When I sit at a table now, it is always nice because we have diversity. I am the Hispanic guy. They have got the black person, the Asian. They bring in the Native American. We all wear the same jackets. We all read the same books. We all have the same titles. But everybody who we are going to try to help is not sitting at the table with us. I always found that somewhat interesting. We need different people. And when I say “diversity,” why is socioeconomic diversity not included? Why do we think that we have answers because we have the education, when we really do not?

I will give you a perfect example. Socrates had taught us to question assumptions. We asked homeless children what they wanted for Christmas because, you know, everybody gets presents during the Christmas season. And you know what a kid told us? Socks and underwear. Nobody gives us socks and underwear. Well, who would have thought?

Is that the first thing that comes to your mind when you are thinking about poor children, that they need socks and underwear? Or are you thinking about the toys that they can have because, you know, we have given toys to our own children?

When I ask my kids what is it they want to give, they give stuff they do not want anymore. And the worst part is, you know what, when the poor kids are sick, guess where they get to come? To our clinics, where everybody knows, "Hey, the clinic is for those poor folks," because they are different, you know? But when you meet the workers, when you meet the patients, you meet the salt of the earth. You meet the people who might have the answers.

I ask you a question—we are in Florida, it is July, 90 degrees and 100 percent humidity—how long do you think you are going to last outside with the mosquitoes? They seem to make it. You are a diabetic. You live under a bridge. How long do you think syringes are going to last? Do you think you are going to maintain that American Diabetic Association diet?

You have coronary artery disease. What is really cheap? Give them nitroglycerin sublingually. We know it works. But wait—read the bottle. It says, "Don't expose to heat or light." Well, that is out for our patients in Miami.

You work in a labor pool. God, your back hurts. Here, take an Advil. Oh, it says, "Eat after meals." So you have got wait for the church van to come by. God, they are all alcoholics or drug addicts. We are not; they are. We are not because our wine is really expensive. And we buy the very best vodka or beer. Do you really think that there is much of a difference in substance abuse issues?

Do you want to talk health disparities? I will give it to you very simply, folks. You are poor, you are black, you are Hispanic, you are screwed, because they have the highest rates of uninsured, the highest rates of uninsured in fully employed families, they work as hard as we do without the resources and the benefits, and they cannot get into a clinic. We have the clinic open until 5:00, but they cannot get off work until 6:00. And we have policymakers who do not make it work. So we have to turn around and say, "Make it work." We have got to push the issue.

When I go to Washington, I can complain about the fact they have cut my reimbursements and my procedures by 40 percent since I started. I still live in Coral Gables. My kids still go to private colleges. I chose medicine, not industry. I make a great living. But when I am up there, I can have a voice for somebody who is not offered that voice in a representative democracy, and those are the poor, the undocumented, the homeless. I am sorry that I use the term "homeless," because what I have done is I have segregated out a group. It is really the most visual reality of poverty in this country. It is increasing, and we have got to do something about it.

Do you know why we have got to do something about it? Because it is our simple responsibility, and that simple responsibility got a little bit more complicated when you got an education and you had resources, and you decided you wanted to be on the board or work in this field. Yes, the burden is heavy, and, yes, sort of a pain sometimes, but that is the responsibility that sits with you.

It was a Tuesday night at the clinic when a young woman in a tattered red dress came in. She was about 25 years old, but she seemed a lot older, the lines of her battle-weary face barely concealed beneath a smudge of stale makeup. Her soiled clothes, made of spandex, told the story of her hard life on the streets. Her eyes revealed her turmoil. Whatever her story, she deserved a bath and a rest.

That night I was working with third- and fourth-year medical students, and I sent Carlos, a third-year student, into Room 2, where she sat sobbing. "Dr. Greer," Carlos called out as he came out of the room. In a hurried tone he said, "I can't get a story out of her. I don't know what it is."

I said, "What do you think it is? Is it physical? Is it psychological? Do you think she's on drugs?" He said, "I don't know. She's crying like a baby. She won't talk to me." He opens up the chart, he says, "Look, she's been here once before, some dermatologic problems. Nothing psych in the chart, Doc. Oh, yeah, by the way, it says she smokes crack. Must be the benefits of prostitution."

We stepped into the exam room. We found a desperate woman. She was trembling. I extended my hand to greet her. When you are allowed to become a physician, one of the greatest privileges and honors you have is that we touch other people. That is a very sacred thing. We are here to help you. "Do you hurt somewhere," I asked, gently nudging her elbow to give her a sense of stability. She was full of tears, gasping for air. "It hurts down here," she said between sobs, holding her lower abdomen, doubling over. "It feels like it's burning. It won't stop. Please help me. Please."

We let her calm down a bit before we examined her. As I palpated her tender belly and examined her further, we concluded that with her history and her signs and symptoms she was suffering from pelvic inflammatory disease and other sexually transmitted diseases.

"It'll be okay," I told her, trying to offer her a little reassurance. Slowly she began to tell us why she had really come to the clinic when she could have gone to the gynecologist at the public health unit. "I was raped, raped hard last night," she said, as she doubled over again in tears and in shame.

"Why didn't you go to the rape treatment center at Jackson," I said. It is just down the street, less than a mile, and one of the top centers in the country. "Doc," she said, with a look that suggested I should know the answer to my own question, "Look at me. Look at how I'm dressed." She paused and then again broke into sobs. "I couldn't take the comments that people would make."

Buildings, systems, technology, they offer no solace, no empathy, no protection from prejudice, no justice. That is because you can never build a soul. The souls are us, and they are those you fund.

Why do we make those comments? We talk about the barriers to health care. Do we consider the barriers in society where we judge people, where we put the poor in a separate category because they are poor and they are made to feel that way? Where they are more exposed to disease, more exposed to violence, more exposed to violation?

She was right. This mammoth system of health care we have can offer excellent medicine. It offers the best care. We have all the best technology. But buildings, systems, technology, they offer no solace, no empathy, no protection from prejudice, no justice. That is because you can never build a soul. The souls are us, and they are those you fund. Those you fund are the souls of the health care systems. They are the souls of the societies. They are the ones who are extending their hands to help this lady, to help that child, to help that man. That is who you fund. You fund not the program, but you gave somebody protection from prejudice.

We have to start in our own backyards, in our own homes, in our own minds. We have to let it go that way, because one of the things I have learned in all the years I have done things is we need to educate the educated. We need to educate those who make the rules. That is how society works. People work hard to get the positions. So when we get to these different positions, we have access to those in power. You have access to those who have no power. Listen to their voice, and talk about that to those who make the changes.

Save not one life, but save them all. Remember it is each an individual life; you save it one at a time. That is what we need to do. We need to go out there, and we need to feel those hearts. We need to listen to those souls. We need to touch those minds. We need to bring that information back when we sit down and make our decisions and our choices.

Then we have got to make sure that the money is spent wisely. We need to do analysis, we need to do policy, we need to do things such as what we did here with the W.K. Kellogg Foundation. Some of you are familiar with the foundation's *Community Voices* initiative, which has tried to improve access and health care for people in 13 communities. Because of the studies that were done with *Community Voices* here, we were able to change policy in Dade County. With people such as Steve Marcus, who was one of the chairmen of the Healthcare Access Task Force—and I will give him credit for this—they have formed in Dade County, as part of the *Health Care Initiative*, a policy board that will oversee health policy for the county.

Another example is a young woman here in Miami, single, three children, two teenage boys. She gets her master's degree and runs a clinic for undocumented aliens. Those are the people you listen to. Those are the stories you listen to, and you listen to the stories of the patients. You guys are the gasoline that allow these engines to run.

And you listen to people like that woman. Yes, what can you learn from a homeless hooker? You know what you can learn? You can learn we judge too much. You can learn the importance of every single individual as an individual. You can learn the fact of how people suffer in this world because we—and I include myself in this—have not done enough to change it to make it so they do not suffer. We can blame the Administration. We can always blame the Administration. This one you can blame in particular. But we are in America; we are the government. We do not have leadership in this country. We have people who get elected who follow what we say, so let us say what needs to be done. And if we say what needs to be done, they will follow. They will do what needs to be done.

I am going to end up with a story, because this is a story that motivates me incredibly and acts as my catalyst, just like my sister's death.

One afternoon around lunchtime I walked into the clinic with a sandwich. This is our old clinic. And in the back area of the clinic we had a waiting room. And then there was a glass door where we had the pediatric waiting area for the mothers and the volunteers who would help the kids and give the moms a little break. I greeted the patients in the waiting room like I always do, joke around with them, "Where are you from?" You know with all the Latin Americans and those of us from the Caribbean, I always welcome them into exile.

I then walked into the pediatric area where I found a mother with three of her kids. They had come in from the Salvation Army. And the youngest child caught my eye. He was a little boy about six years old. He had a sweet smile. And I walk in with a sandwich. Come on, folks, I don't need the sandwich. So I took the sandwich out and I gave it to the child.

I want you to put yourself outside of the luxury of a nice hotel. I want you to put you in the reality of an area where people have not bathed. I want you to put yourself in a place where curse words are everywhere and tattoos are everywhere. The decorations we put up, some of it was there, some stolen.

And you walk in past this little glass door into an area where there are little kids, little kids whose world this is. When they are sick they get to come to us because they are poor folks. And I gave that child my sandwich. The kid took the sandwich out of the bag and unwrapped it. He broke the sandwich in half and he took a bite, put it back, wrapped it up, and stuck it in his pocket.

What the hell is this kid doing? I mean, I know I am not the brightest thing on earth, but you know, I did go to graduate school, did postdoctoral stuff, you figure somebody has taught you something.

Can you imagine, what it is like to be a homeless kid? Do you ever think about that? I mean, I have kids. My daughter goes to a private college. We vacation in Europe. I have exposed them to the world. That is what we do, because that is the best education.

And this kid, when he is in school and the teacher says, "Draw me your house," what is he going to draw, a shelter, maybe a car? A cramped little apartment that is dirty? If somebody invites him to his house, does he get to invite him to the shelter? And if he has had a bad day at school, what is he going to do, talk it over at the family dinner?

I looked at that little boy and I said, "Why did you do that? Why did you put that sandwich back in your pocket?" And his answer stunned me. That little boy looked up and said, “It’s for my brothers.” He was hungry, but he knew how hungry they were. Here was a child who, without cognitive thought, turned around and thought about others. He did not have to analyze it, he did not have to process it. He just did it, in a state of want.

I have been allowed to study medicine to explore the depths of disease and its treatment. God has given me brilliant professors and mentors. He has opened the tools of healing and placed in my hands the most precise instruments of modern technology.

And folks, on any afternoon, God has given me the most remarkable post-graduate opportunities—allowed me to find them in the city of Miami, under a bridge, in an emergency room, in the waiting room of a neighborhood clinic, in the wisdom and humanity of a homeless child.

I am going to ask you this question: the goodness of that child has stayed with me through the years, and I have often wondered, could that child’s lesson in generosity be multiplied by community, by state, by country, and by world?

If I leave with one message today—as you sit there deciding the fate of people, and you do a great job doing it—it is to ask you to become that six-year-old child. If we can all aspire to be him, the world would be just a little bit better.

Putting People First

Lauren LeRoy, Ph.D., Grantmakers In Health

I want to welcome you to the Grantmakers In Health (GIH) Annual Meeting on Health Philanthropy. We want you to enjoy yourselves with your colleagues in these lovely surroundings, but we also have to get down to serious business. We are here in sunny Florida with palm trees swaying outside our windows, and the riches of this state surrounding us. At the same time, let's remember that only four states have more uninsured adults than Florida, and that the state ranks third in the nation in the number of uninsured children. Florida beats the national average in the number of residents living at or below 200 percent of poverty, the number of immigrants, the share of elderly, and in its ethnic diversity. And like most states these days, it is in the throes of a fiscal crisis.

As we devote this meeting to the imperative of reforming our health system to put people first, let's keep in mind the 100,000 children who are now on the state's waiting list for the State Children's Health Insurance Program (SCHIP). Their lack of insurance coverage, and all the factors that make it so hard to bring them into the system, are symbolic of the issues we will address in the next two days as we seek to define philanthropy's role in strengthening our health system.

Our health system is the richest, most extensive, and advanced in the world if we think in terms of dollars, infrastructure, and technology. We are rightfully proud of the progress made in health and medicine in our lifetimes. Yet there is strong evidence that our system often does not deliver the care that people need. In fact, it too frequently harms them. It is myopic in its focus on individual care rather than the public's health. It rations services, not through explicit policy decisions, but by income, race, and visa status. It emphasizes treatment over prevention. And it leaves millions of people disenfranchised while it wastes billions of dollars on unnecessary care. We, as consumers and health experts, know the system is ailing, and the health professionals we depend on see the risks up close.

Walter Cronkite put it succinctly when he said: "America's health care system is neither healthy, caring, nor a system." And it grew into this paradox through a combination of:

- good intentions,
- scientific achievements,
- vested interests,
- insatiable appetites,
- prejudice,
- fragmented decisionmaking, and
- economic incentives.

The distinguished committee of the Institute of Medicine (IOM) that considered these issues concluded in its report, *Crossing the Quality Chasm*, that "The current care systems cannot do the job. Trying harder will not work. Changing systems of care will." Systems change of this magnitude is a tall order. We need a vision, a direction. The *Quality Chasm*, and

> *"...we can now insert enough prosthetic devices...and transplanted organs...to create a six million dollar man or woman."*
>
> GEORGE HALVORSON AND GEORGE ISHAM, EPIDEMIC OF CARE

> *"Your chance of dying from simply being in the hospital is...twenty times higher than flying in a commercial aircraft."*
>
> GEORGE HALVORSON AND GEORGE ISHAM, EPIDEMIC OF CARE

"Old age is a territory largely populated by women."

ROBERT BUTLER,
INTERNATIONAL
LONGEVITY CENTER

the IOM's recent report on the future of the public's health, provided one such vision. And together, they chart a path where, as Donald Berwick, president and CEO of the Institute for Healthcare Improvement, has said, "...true North (on the compass) lies in the improvement of the experiences of patients and communities, and nowhere else."

Our keynote speaker, Harvey Fineberg, president of the Institute of Medicine, will help us chart a path to a better future. In the meantime, if we can agree that the fundamental purpose of our health system is to serve patients, families, and communities, then, in order to put people first, perhaps we should start by answering the question "who are these people anyway?"

In 2000, the nation had over 281 million people. Numbers alone don't tell the most important stories, however, like the fact that those over 65 will make up an increasing proportion of the population in the coming decades. So, let's turn first to the elderly, because their numbers and needs will have a profound impact on the health system in the future.

ELDERLY

The U.S. population is growing older, a trend that will become even more evident when the baby boomers begin to retire in significant numbers in 2010, only six years from now. All you have to do is visit the cosmetic aisle of your local drug store, where acne lotions have been pushed aside to make room for a whole new section of so-called age-defying products, to know that this is likely to have a transformational effect in many sectors, including health care.

We also need to look beneath the aggregate numbers to fully understand the challenges in this tidal wave of aging. The disparities in life expectancy between men and women are projected to narrow only slightly, meaning that many elderly women will find themselves alone. These women have often been the primary caregivers for their loved ones. Left alone, they must rely on community resources or family (more often than not, their working daughters—the classic sandwich generation—who also have children to care for). Most people prefer remaining at home; and the billions of dollars in free care they receive from family takes some pressure off the nation's health care bill.

Informal caregivers play a vital role, personally and financially, one that will become increasingly strained as the number of adults under 65 declines relative to the number of elderly, from 10 to 1 in 2010 to 4 to 1 in 2050. While whites will remain the dominant racial group in the baby boom generation, the numbers of racial and ethnic minorities will grow considerably over time. By 2050, minorities will represent a third of those over 65, as opposed to 15 percent today. Unless we explicitly address the factors that create disparities in health and health care for racial and ethnic minorities, we can expect them to persist as people age.

The health status of Americans has improved considerably over the years, and we see it in the number of elderly people who continue to lead active and productive lives. The vast majority of people live independently, often remaining in the homes where they raised their families. Over time, we can expect their aging in place to require increasing support from family and community-based services, which, these days, are often fragmented, difficult to find, and financially out of reach. Let's also remember that nearly 90 percent of people over 65 live with some type of chronic illness or condition. Not all chronic conditions limit people's daily functioning, but they all require attention and effective management. And, with a health system that is structured around acute rather than chronic care, the needs of the aging boomers will create profound stress and pressure for change.

RACE AND ETHNICITY

The demographics of the nation are changing, not only by age, but by race and ethnicity. People of color now make up nearly a third of the U.S. population, and that number will rise to nearly 40 percent by 2030. And, we are talking about extremely heterogeneous groups of people. For example, among Hispanics, almost 60 percent are of Mexican origin. The other 40 percent have their family roots in Puerto Rico, Central America, and South America. Both access to care and the quality experienced by Hispanics varies by country of origin and facility with English.

Asians are the fastest growing racial group in the country. Like Hispanics, the Asian population is highly heterogeneous, and country of origin and facility with English again have an impact on access and quality.

We must keep in mind that these different racial and ethnic minorities are not evenly distributed across the country. For example, Hispanics make up a third of the population of California and less than 1 percent of the state of West Virginia. Providing care to such a diverse population is challenging, and, in many instances, we have not measured up. The United States remains highly stratified on the basis of race, ethnicity, and socioeconomic status, and these differences carry over to people's health. We all know the data: racial and ethnic minorities tend to be in poorer health, have more difficulty getting access to care, and receive lower quality care than whites.

The reasons for differences in health status are complex. Changes within the health care system are critical, but they alone will not close the gap that is defined by:

- disproportionate exposure to environmental hazards,
- poverty,
- cultural ignorance, and
- racism.

The roots of disparities run deep. Keeping the inequities of the past and present from defining our future will require a sustained societal commitment. And, we cannot fully appreciate the challenge unless we also understand the role immigration plays in defining who we are as a nation. Between 1990 and 2000, the foreign-born population of the U.S. increased by 44 percent. Roughly 700,000 new legal immigrants arrive annually; and those who enter the country illegally add to their ranks. Of those arriving each year, nearly three-quarters are Asian or Hispanic. Over 300 languages are now spoken in the United States, and nearly 47 million people speak a language other than English at home. Just south of here, in Miami/Hialeah, 82 percent of the city's population speaks a language other than English at home, and over a third report not speaking English well or at all.

We again find great diversity within the immigrant population, by both language and culture. While Spanish is the lingua franca across Latin America, each Asian country has its own national language as well as multiple dialects. Deciphering health insurance options, finding useful information on healthy living, and communicating effectively with health care professionals are difficult enough for native English speakers. Imagine trying to do so in a system where nearly no one speaks your language. Imagine how vulnerable or uncomfortable you would feel if the only link between you and your doctor or public health officer was the office janitor or your 8-year-old child. We are also all products of our culture, which influences our views and behaviors regarding health and illness. As Anne Fadiman's book, *The Spirit Catches You and You Fall Down*, graphically illustrates, ignorance of cultural differences and disregard for the role culture plays in health and healing can have dire consequences.

HEALTH SPENDING

Health care costs rose to $1.6 trillion in 2002. After several years of large increases, spending growth showed signs of easing last year. Increases in health insurance premiums and out-of-pocket costs, on the other hand, showed no signs of abating. The United States spends more per capita on health care than any other industrialized country, while falling behind other nations on key health indicators. Our seeming inability to control health care costs contributes to both the causes and consequences of being uninsured.

UNINSURED

Nearly 44 million people were uninsured for the entire year in 2002. It's hard to pick up the newspaper these days without being reminded of the pain this causes. The number of people with employment-based coverage has dropped, and the rise in government insurance programs has not offset the decline in private coverage. We all know the startling statistic that 8 out of 10 uninsured live in families where one or more adults is working. And, among the poor, those who are working are less likely to be covered than nonworkers.

Across the states, we see tremendous variation in the proportion of people without health insurance, from 8 percent in Minnesota to nearly one quarter of those in Texas. Many people currently piece together their insurance, experiencing gaps in coverage during the year. If we add them into this picture, over 25 percent of the population was uninsured for at least part of the year in 2002. Those without insurance must dig deep into their pockets, trade off food or rent for medicine, and rely on the safety net of public hospitals, community clinics, and health centers for care. The safety net has often surprised us with its resilience; but it is always in jeopardy, particularly with a weak economy and state budget shortfalls.

Americans who are fortunate enough to have employer-based health insurance coverage are concerned as they face consecutive years of rising costs. Those with retiree health insurance benefits have been similarly affected. These are discouraging signs in an already bleak picture of eroding retiree benefits.

RECENT TRENDS IN EMPLOYER-BASED COVERAGE

- Premiums up 14% in 2003 and 50% in past 3 years
- More deductibles, coinsurance, and benefit constraints
- In 2002, among large employers offering retiree benefits:
  - 44% increased retiree contributions
  - 80% likely to increase future premiums
  - 13% eliminated retiree benefits
  - 22% plan to eliminate retiree benefits
- 66% of large employers offered retiree health benefits 15 years ago; only 38% offer benefits today

SOURCE: Gabel, Jon, Gary Claxton, Erin Holve, et al., "Health Benefits in 2003: Premiums Reach Thirteen-Year High As Employers Adopt New Forms of Cost Sharing," *Health Affairs* 22(5):117-126, September/October 2003.

"Cancer killed my brother, but he died because he was uninsured."

LT. EDWARD GREGORY PEREZ, DENIED: THE CRISIS OF AMERICA'S UNINSURED

Lack of insurance coverage:

- impedes access,
- often results in poor-quality care,
- reduces labor force participation and productivity, and
- kills people.

The IOM estimates that each year, 18,000 people age 25 to 64 die because of lack of health insurance coverage. As Karen Davis, president of The Commonwealth Fund, noted in congressional testimony last year "Such numbers make a compelling case for addressing this national disgrace."

CHRONIC ILLNESS AND PUBLIC HEALTH

Whether insured or not, many of the people we are focusing on today suffer from chronic illness or are living in ways that put them at risk. The five chronic diseases of heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes alone account for two-thirds of all deaths. And at the root of these diseases are factors that the health care system has only limited capacity to affect. The top 10 underlying causes of death make clear the toll we pay, both individually and as a society, for unhealthy behaviors. A large part of the nation's health care bill is for medical expenses related to these behaviors.

Within 15 years or so, chronic care costs will exceed 80 percent of our total health spending. In this case, an ounce of prevention could be worth billions of dollars in health care savings, to say nothing about prolonged lives and reduced suffering. Unfortunately, the impressive advances in medicine over the years have reinforced the illusion that medical intervention can mitigate the effects of our unhealthy behaviors and neglected social conditions. As we've been told so often, however, our ability to diagnose and treat

TOP 10 UNDERLYING CAUSES OF DEATH

- Tobacco
- Poor diet
- Lack of exercise
- Alcohol
- Infectious agents
- Pollutants/toxins
- Firearms
- Sexual behavior
- Motor vehicles
- Illicit drug use

SOURCE: McGinnis, J. Michael, and William H. Foege, "Actual Causes of Death in the United States," *Journal of the American Medical Association* 270(18):2207-2212, November 10, 1993.

disease has had only a modest impact on the public's health. Making progress will require a system that integrates the multiple factors affecting health, combines attention to acute care with management of chronic illness, and moves us from a focus solely on the individual to population-based principles that are the foundation of public health practice.

Obviously, our public health system has a major role to play in the new paradigm. It has an illustrious record of achievements, but it also has a troubled history. The firm grounding of our public health system in disease prevention and health promotion began to soften as its role as a safety net provider in the medical care system grew. Underfunded, undervalued, and ambiguous about its mission, our public health infrastructure, unfortunately, reflects the priority we, as a nation, have placed on it. People also don't understand its role. And the better public health does its job in protecting us, the more invisible it can be from the public's eye. This can work against efforts to strengthen the system.

Spending for public health is a small fraction of total health expenditures in the United States. It took something as horrific as the events of September 11th to crystallize for the public the importance of a highly functioning public health system, and to unlock new resources. The question is whether we can sustain that commitment and not let our fears of biohazards outweigh broader population health needs.

Government has a key role to play in supporting core public health functions. But promoting and safeguarding the public's health requires multiple community partners, including the medical care system and philanthropy. We all know that partnerships take much care and feeding. Nonetheless, creating the conditions that promote health has enormous implications for the disease burden of our population and our ability to rein in health care costs.

GAUDEAMUS IGITUR

Excerpt of a poem written and read by John Stone at a graduation address for the class of 1982 at Emory University School of Medicine.

For this is the day you know too little
    against the day when you will know too much

For you will be invincible
    and vulnerable in the same breath
    the breath of your patients

For their breath is our breathing and our reason

For the patient will know the answer

For there may be no answer
    and you will know too little again
    or there will be an answer and you will know too much forever

For you will look smart and feel ignorant
    and the patient will not know which day it is for you
    and you will pretend to be smart out of ignorance.

WHAT PEOPLE WANT

Trying to describe in a few minutes the people we all serve and the issues they face is an impossible task. I have barely scratched the surface. The sessions during the next two days will help to fill in the picture, as they zero in on different segments of our population. These include people who are trim and fit or overweight and physically inactive. They live in both urban and rural areas. They include children who are vibrant and others who are vulnerable. Some are disabled. Many are living with mental health problems. A good portion work in the health sector. Some are financially secure, while others are poor. Increasing numbers are turning to information technology, but they don't always find it easy to interpret what they find.

Let's not forget as we talk about people trying to navigate the health system that their issues get very personal. There's much to learn from their stories, and from our own. I recently found that when you give people a chance to speak, they have much to say. In preparing for this speech, I asked friends and colleagues to tell me what they, as consumers—not health experts—saw as key characteristics of a well-functioning health system. I didn't want this to be a burden for them; "just a few words or phrases will do," I told them.

I was literally shocked when I realized that I had unleashed a torrent of concern and expectation. It was more than I could possibly convey in this speech, and yet, I felt a responsibility to share this outpouring in a condensation of their words.

> *"...the U.S. system rarely outperforms other nations surveyed; on most measures of quality of care, it ranked last or second-to-last."*
>
> KAREN DAVIS, ET AL., TIME FOR A CHANGE: THE HIDDEN COST OF A FRAGMENTED HEALTH INSURANCE SYSTEM

WHO WE ARE

44 million adults are obese, and 9 million children between the ages of 6 and 19 are overweight

79 percent live in urban areas

26 million kids are on SCHIP or Medicaid

8.5 million children are uninsured

50 million people have disabilities

20 million adults experience daily depression

10 million work in the health care sector

12 percent live in poverty

110 million sought on-line health information in 2002

SOURCES: Bureau of the Census, Department of Commerce, *United States Census*, 2000 (Washington, DC: 2001); Centers for Disease Control and Prevention, "Prevalence of Overweight Among Children and Adolescents: United States, 1999-2000," <http://www.cdc.gov/nchs/products/pubs/pubd/hestats/overwght99.htm>, accessed on September 26, 2003; Mokdad, Ali H., Earl S. Ford, Barbara A. Bowman, et al., "Prevalence of Obesity, Diabetes, and Obesity-Related Health Risk Factors, 2001," *Journal of the American Medical Association* 289:76-79, January 1, 2003; Wurman, Richard Saul, *Understanding Healthcare* (Newport, RI: TOP, 2004).

There are also more rigorous efforts to capture people's views and experiences, like the surveys of The Commonwealth Fund, which make clear the challenge we face. And people are concerned: A recent Harris Interactive poll reported that two-thirds of the public are pessimistic that the health care system will improve in the next five years.

In planning this conference, I also debated whether we needed to hear up front from a consumer, a real person, in order to illustrate the shortcomings of the current system. But, I decided against it. I think it's time we brought this issue home by integrating our own experiences—as patients and advocates for family or friends—into our professional work on system reform.

It was easy for me to make it personal by simply thinking about my parents. I have much to thank my parents for, and you can guess what some of those things are. There is one that you might not think of, however, and that is their need and willingness to let me help them navigate the health care system, particularly in the past 10 years. My (or I should say our) experiences, from simply trying to schedule an appointment, to standing guard over them in the hospital or nursing home, to searching for affordable community-based services, to making life and death decisions in a 15-minute office visit, have made our system's failures and successes more palpable to me than any report or study could possibly do.

In the end, we, too, are those people this conference is championing; we are all witnesses to the gaps between knowledge

CHARACTERISTICS OF A WELL-FUNCTIONING HEALTH SYSTEM

Responses to an Informal Survey

- An insurance system that doesn't let people down when they need it most
- Coordination among providers caring for me
- Efficient communication between my providers and insurer
- Insurance I can afford
- Not getting mixed messages or conflicting information from my doctors
- Respect for the family's role in patient care
- Easier ways for uninsured people to find sympathetic providers
- Not having to provide the same information repeatedly
- One medical record
- Not fearing for my life when I go to the hospital
- Time to get my questions answered without being rushed out the door
- Patients being treated with respect regardless of race, sexual orientation, insurance status, or age
- No surprises
- Easy access to information on:
  - how to take care of myself
  - my health problems
  - recommended medical treatments
  - prescribed medications
  - community services
- Providers who take the time to listen
- Recognition and respect for alternative family structures
- Getting the information I need about my treatment to do my part and be prepared for side effects
- Providers who don't act defensive when I raise questions or refer to information I've gathered
- Support staff who are facilitators rather than gatekeepers
- Appointment systems that acknowledge that patients also have commitments
- Flexibility to accommodate different family circumstances
- A system that is not xenophobic or homophobic
- A system where I don't need a Ph.D. and 20 years of health policy experience to make an informed decision about my health insurance options
- Sensitivity to the needs of elderly patients
- A system that doesn't waste my time
- Patients' ability to get good care regardless of what language they speak
- Care that takes into account people's cultural backgrounds
- Doctors who see me as a partner rather than a case to dispense with
- A system that makes the most out of information technology
- Getting my phone call to the doctor returned by someone (anyone) within 24 hours
- A system that would never again leave my elderly dad alone on a gurney
- Being able to communicate with my doctors by e-mail
- Doctors who understand that a condition common to them can be a big deal to a patient experiencing it for the first time
- Not having to wait forever to get an appointment
- A system that's safer than the airline industry
- Providers who follow through when they say they'll do something
- A system that is more efficient and less wasteful
- Costs that are not out of this world
- Hospitals, nursing homes, and clinics that monitor how they do things, both clinically and administratively, and care enough to improve their performance
- A system that doesn't expose me to unnecessary tests, procedures, or drugs
- A system that gives me tools to live a healthier life
- The best protection from public health threats that money can buy
- A new culture of equity, safety, and efficient use of resources
- Simplicity
- Making it easier to get through the health care maze
- A system that doesn't make me feel like I'm a burden
- We probably want to be treated by doctors the same way that grant seekers and grantees want to be treated by funders

and practice, stated priorities and allocation of resources, caring and indifference, and consumer empowerment and dependency. And we are the lucky ones. If the system fails us, it fails everyone.

These are harsh words, particularly coming from an inveterate optimist. But there are many rays of hope as well. We have:

- a rich evidence base to guide practice,
- tremendous advances in information technology to apply in both medicine and public health,
- a transformation in understanding about what contributes to health,
- exemplary practice and many community models that prove change is possible,
- blueprints like those of the IOM,
- articulate and tireless champions for change,
- growing recognition among stakeholders and policymakers that change is necessary, and
- (many would argue) the resources to do it right.

Philanthropy clearly has a role to play in supporting these efforts. Many of you already do and will have the opportunity to share your work with your colleagues during the next two days. This is hard work. It requires a culture shift, political will, passion, optimism, true grit, commitment, and leadership. And these same qualities are what we need in philanthropy to address some of the most pressing issues for the field itself—issues that also call for rethinking the way we do our business.

In the past few years, increased public scrutiny, along with investment losses and government fiscal crisis, have stimulated concern, self-reflection, and change across foundations and corporate giving programs. We have seen some recovery in the stock market this past year, although it has not been a ride for the fainthearted. Grantmakers are cautiously moving forward while doing their best to protect their investments. The Center for Effective Philanthropy reported that of the 250 largest foundations in the country, most will hold the line on payout in 2004; the good news is that one-quarter plan to give more.

Even if conditions improve, the trauma of large portfolio losses, occurring at the same time that grantees' needs were rising, will not fade quickly, particularly when the public sector is still drowning in red ink, and we know philanthropy can't make up for the deficits and cutbacks. These economic conditions have stimulated healthy debate on a number of issues; and those debates will likely continue. They also reinforced efforts to more rigorously define expected outcomes from foundation investments and develop methods to measure them.

The increased scrutiny of philanthropy, during this same time period, may have had a perverse effect on some of the practices funders have adopted. For example, in their efforts to be more accountable in their grantmaking, funders have been hesitant to provide core operating support at a time when some argue that many nonprofit grantees are too strained by increased demands for essential services to take on new innovative projects. And while some foundations have simplified their procedures to reduce pressure on their overextended grantees, others have tightened up—in the name of accountability—in ways that ultimately may render their grantmaking less effective.

We still struggle with how best to measure performance—our own or that of grantees. Grantmaking takes place in a complex social environment and is rarely the only factor affecting how things turn out. Capturing what truly matters and can inform our future work (those lessons learned we all desire) often requires looking deeper into the stories behind the measures. Our attention in recent years has been focused on improving accountability in grantmaking. At the same time, the well-publicized scandals of this past year suggest that equal emphasis must be put on governance. We shouldn't delude ourselves into thinking that this is an issue for only a few bad apples. Let's not forget that among the most egregious cases reported so far, there are some well-respected colleagues and organizations.

The high ethical standards that regulators, grantees, and the public should expect from us, and we should expect from ourselves, challenge every organization to re-examine its governance structure and policies. According to the Center for Effective Philanthropy, this issue has been explicitly addressed by the boards in three-quarters of the nation's largest foundations. About one-third made changes in their policies in such areas as conflict of interest, review of tax returns, and establishing audit committees.

Changes like these can address some of the immediate issues of the day; but, according to the foundations' CEOs, they fall short of creating the conditions for a truly effective board. And those all relate to active engagement by trustees in developing strategy, assessing performance, contributing expertise, making foundation business a priority, and representing the foundation to the public.

Ralph Smith, vice president of The Annie E. Casey Foundation, pointed out in a recent interview, "repairing the public trust requires better self regulation." There are different opinions about whether and how this should be implemented for the field as a whole. Regardless of the outcome of that ongoing debate, however, there is no reason not to start closer to home. Only 21 percent of the boards in the nation's largest foundations currently have a formal process for evaluating their own performance. Raising that number seems like a reasonable first step. And as foundations and their trustees take a closer look at themselves, they should also consider how well the composition of their staff and board reflects their target communities, grantee organizations, and mission.

There is much talk about diversity and inclusiveness within philanthropy today. We must ensure that it is a precursor to action, both to consolidate our gains and to make needed progress. Let's consider the numbers for gender and race from a report by the Joint Affinity Groups to illustrate the point. Over the last 20 years, philanthropy has evolved from a field dominated by white men to one where two-thirds of the professional staff are women, and people of color make up a fifth of the staff. These impressive changes, however, have not carried over to foundation boards, which have changed little in terms of diversity over the past two decades. Men comprise 69 percent of foundation boards, and 89 percent of

> *"...under current circumstances, [providing core operating support] is one of the most strategic things foundations can do."*
>
> GARY YATES,
> WHAT ROLE SHOULD FOUNDATIONS PLAY IN INCREASING RESOURCES FOR CHARITIES IN TOUGH TIMES?

> *"...strict agreements, emphases on metrics, abbreviated funding commitments, skimping on overhead, and tying grants to specific projects have a debilitating effect...."*
>
> EDWARD SKLOOT,
> PHILANTHROPY: WHAT'S LOVE GOT TO DO WITH IT?

board members are white. Moreover, as we know, the numbers alone do not tell the whole story. For example, minorities continue to be greatly underrepresented among CEOs. Men of color appear to be having greater success than minority women; but, in both cases, they are concentrated in certain types of foundations and less frequently reach higher-level positions. The impressive gains of white women are tempered by trends that look similar to some other female-dominated, pink-collar professions like teaching and nursing, particularly women earning less than their male counterparts.

Changing the mix of staff and trustees alone, without building an inclusive organization, can create skepticism and disappointment both within and outside of the organization. Again, this requires culture change, which, in turn, requires leadership. We don't always know where leadership for change will come from, but we should at least expect it of those at the top of their organizations. And, this raises an issue that we should put on our radar screens.

We need to be prepared for the fact that many of today's leaders are likely to catch the retirement wave that will rise with the baby boom during the next 10 years. In the past year or so, over 15 foundations familiar to health grantmakers announced changes in their leadership or transition plans. A recent survey of community foundation CEOs by Transition Guides and Management Performance Concepts for The Annie E. Casey Foundation found that 55 percent of them planned to leave their current positions within five years. And over three-quarters of their foundations did not have formal succession plans. Changes in leadership can be unsettling under the best of circumstances. Poorly managed executive transitions can impose high costs on organizations. Done well or poorly, the appointment of a new CEO will have ripple effects throughout the organization. Changes at the top are often followed by changes in the management team. Transitions provide the opportunity to re-examine the foundation's priorities and organizational practices. This can be an exciting time, but it also creates uncertainty and anxiety for both staff and grantees. It takes time for staff and board to adapt, but the work must go on. Communications, both externally and within the organization, become crucial at this time.

Whether we are working to transform the health system to put people first, or we are working to strengthen philanthropy to improve people's health, we face huge challenges that require rigor, passion, commitment, and leadership. We're often clearer about the problems than we are about the solutions, but that's a good place to start. As those famous diagnosticians, Click and Clack, the Tappet Brothers from Car Talk, remind us: "A problem well defined is a problem half solved."

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A Health System for the 21st Century

Harvey Fineberg, M.D., Ph.D., Institute of Medicine

Let us begin by stepping back a bit to understand what is shaping the health environment we find ourselves in today. I would like to offer 10 forces that are influencing the way health care is experienced by individuals and practiced in our society.

The first of these is the incredibly continuing, even accelerating, pace of advances in science, introduction of technology, and its deployment. This is both a force for good and a source of trouble. We have invested in doubling the National Institutes of Health budget towards development of the future solutions to the health care problems we are experiencing today. Fifty years ago, the United States had its first randomized clinical trial. Twenty years ago, there were about 100 clinical trials that appeared in the literature every year. Today there are more than 10,000 published annually in the world's literature. So the pace of learning about what could be done to benefit patients in the ideal evidence-based sense is growing enormously. That presents an opportunity and a challenge.

The second problem or force is the transition, both demographically and epidemiologically, that produces the growing prevalence of chronic diseases as dominant problems that the health system has to solve.

10 FORCES ACTING ON HEALTH CARE

- Scientific advances and new technology
- Growing prevalence of chronic disease
- Globalization and emerging diseases
- Bioterrorism and the interface between medicine and public health
- Persistent economic exigencies
- Legal and regulatory pressures
- Professional discontent and shortages
- Rising expectations
- Patient empowerment and interest-group politics
- Uncertain system reform

The third force is the globalization, both of decisionmaking and also, most significantly, of the experience of illness. We heard about the numbers of immigrants entering the United States legally; one can double that for the number of total immigrants per year. Travel today is something that every person experiences in the course of his or her lifetime in the United States. The number of people going to exotic places abroad increases dramatically year by year. This, in turn, means that people are being exposed to new experiences but also to new biological environments.

The shipment of goods and the growing exchange of commerce also introduces into our country new opportunities for infectious diseases and other problems we have not experienced before. We have, for example, introduced mosquitoes capable of carrying diseases, even malaria, if the conditions are right. Every year in the United States, we have experienced outbreaks of infectious disease that previously were not experienced. So the globalization of illness and thinking about the solutions to those health problems globally are increasing realities and forces. Of course, this applies more than ever to the HIV/AIDS pandemic.

A fourth force is the new concern about bioterrorism, heightening awareness of shortcomings of the intersections between our medical care systems and our public health system that stand at the forefront of our protection and our ability to contain bioterrorism if and when it occurs.

Fifth, even though the markets have improved, providers of care throughout the country are still experiencing enormous strain economically, feeling that they have little capacity to make necessary investments.

Sixth, the system continues to burden providers at every level in communities, in institutions, and in states with a large and growing set of requirements, motivated often by good purpose. Take the Health Insurance Portability and Accountability Act (HIPAA) as a recent prime example. HIPAA represents additional administrative overhead and constraints on the abilities of providers to deliver services to people.

Another force is the growing professional discontent of providers and the resulting provider shortages. Providers, in the face of malpractice premiums, are giving up either all or parts of their practices. The level of morale amongst practitioners is not high. It is not the practice that they entered 10 or 20 years ago. That represents a serious problem.

At the same time, the public has rising expectations for what will be delivered in care. These expectations are legitimate, and we need to fulfill them, but these expectations are increasing at a pace faster than we have been responding.

Going along with that, from a political as well as a personal level, is a growing sense of individual power and authority to take control. The Internet has made a significant difference to the Internet literati, but political interest groups everywhere have had a growing influence in positive and negative ways on the decisions about research investment and about care. The communities that represent patient groups, such as the HIV community or the breast cancer community, have had profound influence on research strategies and on funding in a way that was not evident 20 years ago.

Still today, with all of the troubles, with all of the problems, with all of the burdens of malfunction, we face, even in an election year, enormous uncertainty about system reform. The last great efforts in the Clinton Administration to undertake a total system reform, as we all know, foundered. Ever since then, politically, health reform has been a kind of tar baby. Everyone is afraid to touch it for fear of getting caught in it and not being able to disengage and really work through it.

The importance of health reform politically has never been more pressing than it is today. But we have to recognize, no matter where we sit on the political spectrum, that the prospect of reform of a major type remains very uncertain. It will not happen only on its own accord. It will only be a function of a concerted effort on the part of many people.

I want to touch upon some of the major concerns in health on which the Institute of Medicine (IOM) has worked. This is for the purpose of sharing with you lessons from both the content and strategy of our work. If I leave you with one point about each of these problems that I have just introduced, the one lesson I have learned from my own vantage point within the IOM, it is that these complicated and challenging problems—the public health system, the problem of uninsurance, disparities in care, issues of quality and safety—are not going to be solved in one fell swoop. They are not going to fall before a single definitive study. They are not going to end because of a single model program. In each case, they are going to require sustained and repeated effort. The most important strategic idea I have learned since joining the IOM a couple of years ago is the notion that sustained commitment to whatever problem you tackle and the willingness to come back again and again are essential to achieving long-term success.

I do want to say just a word about each of these, and also to give a little bit of background for a moment about the Institute of Medicine but put it into context for you as to how we approach these problems and what we do. The Institute of Medicine is a part of the National Academies, which despite their location in Washington, are outside of government. They are made up of the National Academy of Sciences, the National Academy of Engineering, the Institute of Medicine, and the National Research Council.

These bodies date back to 1863 when Congress issued their charter. That original charter had some interesting features. First, it said that the academy shall provide advice to any agency of government on any matter of science or art. Art, at the time, meant the practical arts, what we would now think of as technology. Secondly, the original charter specifies that no one who serves to give advice shall be compensated for his or her service. So there was a remarkably, I think, powerful built-in element of public service in the founding documents of the National Academies. They have this duality, being honorific associations with membership and elections, but also having this purpose.

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A lot is known or knowable. But how do we put it into practice? How do we make it actually work for people?

They are outside of government but they are responsible for helping government. I like to think the relationship to government is arm's length, tightly grasped, apart but closely connected.

The beauty of being outside of government is that organizations have the authority for and the possibility of conducting self-initiated work. It does not have to emanate only from government. Fully 25 percent of its support has come from foundations and private sources in terms of its ability to carry out its mandate.

Every year, the Institute of Medicine produces about 50 to 60 reports that grow out of efforts of volunteers, experts drawn from across every sector of society who come together, participate, share their ideas, and grapple with these difficult problems. Before these reports are released, they go through a rigorous review process, and, in the end, receive the imprimatur of the institute. But when a report comes out, the work of the Institute of Medicine is only half completed. All that really matters on any of these subjects is what happens to people in the world. It does not matter what marks you put on a piece of paper and label on a shelf.

So it is that second half of seeing the work and ideas put into practice that I want to leave as a second, important lesson, after sustaining effort. I think without that, nothing that we do will really have had any consequence.

Now in general, as we take a look briefly at these five areas, I just want to again take a step back in terms of how one makes progress in health. You can think of it as having two sort of basic strategies. One is develop better things to do. Experiment, try things out. Take what works. Develop the right products; whether it is a physical product or a program or an activity, conduct the trials, the experiments, the tests. Basically, start with the idea, innovate, and get to the point where you have got something better.

The second strategy is to devise better ways to do what we already know we should be doing. That pertains, I would submit, to care of an individual patient as much as it does to community-based programs. It is figuring out how we improve, for example, access to what is needed. Or how do we make the product get produced more efficiently? How do we make it more effective and better in quality? Those are the sorts of questions that apply to this second basic strategy.

Most all of what I am going to be talking about derive from this second basic idea, the idea that a lot of really good things are there. A lot is known or knowable. But how do we put it into practice? How do we make it actually work for people? How do we make what we want to deliver actually get delivered?

The IOM's first report on public health dates back to an earlier report in 1988, which some of you may remember, *The Future of Public Health*. It was a very critical study. It essentially declared the public health infrastructure of the United States in disarray. It was a kind of rallying cry. It was received with mixed feelings on the part of the public health community.

But it was a very important signal and mostly a key reinforcement of the value that properly produced public health for society.

Just a few years ago, the Institute of Medicine reconvened a group to take a fresh look. That group produced the report *The Future of the Public's Health.* Interestingly the title hearkens back to the earlier report. But the slight shift of the possessive "public's" was intended to signal an important message. That was that public health was not only a governmental responsibility, but this report looked at the value and contribution of each sector in society to assuring and promoting the public's health: the government, the public sector, the philanthropic sector, the education sector, and the health care delivery sector.

A companion report, *Who Will Keep the Public Healthy?*, was directed at education for preparing people in public health, taking a look at the traditional ideas of what constituted proper public health education. It may or may not surprise some of you to know that the vast majority of people currently working as professionals in departments of public health do not have any formal degrees in public health. In addition, the report found that the traditional programs that train people in public health do not have a broad enough grounding in areas of expertise such as global health; health information; and community-based research, which was one of the eight new emphasis areas stressed in the report. So these reports together represent a one-two punch for what public health can be and how we can get there more successfully.

I have been gratified to be invited to a number of communities to participate in discussions between health departments and providers who are using the basic premises from these reports and are trying to come to grips with what they can do locally to help improve the situation.

The solutions partly are local, partly are at the states, and partly are national.

The solutions partly are local, partly are at the states, and partly are national. Health insurance is an area that we have already heard about. Several years ago, with the strong support and collaboration of The Robert Wood Johnson Foundation, the Institute of Medicine embarked on a series of reports to lay out the nature of the evidence about the problem of health insurance, and the nature of the solutions and what they might achieve.

The series of six reports appeared starting in late 2001, with the final report released in January 2004. These reports start with the basic information on the nature of the problem and how serious it is, how many people are affected, and how their health is affected. For example, the kind of data that came out of that report talked about the number of 18,000 lives lost due to lack of insurance.

The later reports say that as a nation, we cost ourselves between $65 billion and $130 billion because we fail to provide health insurance to people. These costs are the result of the patients' additional health cost because of deferred care, and their lost earnings due to their worsened health for failure of insurance.

The final report, *Insuring America's Health*, emphasized the elements that any plan that would solve the problem would have to achieve the universality of care, the continuity of care, and the quality of care. In doing so, the report tried to shape the nature of the debate that has to follow in a political sense if we are going to solve this problem.

There are disparities of care, disparities of outcome, disparities which are not based on legitimate differences in the health of patients but are based on irrelevancies such as where you were born, what the color of your skin is, what your particular ethnic background is. These disparities are not consistent with the ideals of our country and, with care, not acceptable in a health care system that is designed and should be functioning to serve everyone in the country.

We coupled the IOM's original disparities report, *Unequal Treatment*, with a more recent report, again analogous to the public health report and education report, with a companion volume, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, that talked about how we can ensure diversity and achieve it through education.

Now I want to say a word about safety and quality of care because this has been a hallmark of both concerns and attention in a series of reports from the Institute of Medicine. The medical errors report, *To Err is Human*, really caught the public's attention. When there was a survey of the public awareness of the problem a month after the release of this report, more than 50 percent of the public said they had heard about the problem of errors in health care. The president called together a conference at the White House and established an interagency task force. Congress appropriated $50 million more to the Agency for Healthcare Research and Quality to work on safety.

The second report, the companion or counterpart, *Crossing the Quality Chasm*, outlined that the problem resided not in individuals but in the systems of care, the processes and procedures that produced the results that we actually experience. Instead of thinking about our health care system as basically good, occasionally producing errors, the argument here was that every system was perfectly designed to produce the results it actually achieves. If you have 3 percent errors, your system is designed to produce 3 percent errors. If you have three errors per 1,000 prescriptions, which is on average what many studies have shown, our system of prescribing is designed to produce 3 errors per 1,000. If you want that number to be 3 errors per 1 million or 3 errors per 10 million, you have to redesign the system to produce 3 errors per 1 million or 10 million, not 3 per 1,000.

Other studies followed the original studies in what we have come to call the *Quality Chasm* series. One, for example, pointed to opportunities of federal government agencies to take the lead to show by virtue of their own programs and decisions what could be done to improve quality. I might say parenthetically that the Department of Veterans' Affairs is a remarkable example of leadership on information technology and its application and deployment in health care.

The report, *Priority Areas for National Action*, may be especially relevant, especially going back to the notions of chronic diseases as concerns in the United States. Here, at the request of the federal Agency for Healthcare Research and Quality, the Institute of Medicine tried to assemble the evidence around those problems that are both important, that is, highly consequential for individuals and communities, and where there are known treatment approaches not being applied uniformly and universally to improve outcomes. These include concerns such as diabetes and asthma. Do you know that still today half the people who have an acute heart attack do not get beta blockers, a simple cheap medication, proven to demonstrably reduce mortality from heart attacks? Two-thirds of people with hypertension do not have the right care. Two-thirds of those with hypertension are not even known to the system as having hypertension. So there is a lot of opportunity for improvement.

Finally, the most recent report in the series, *Patient Safety: Achieving a New Standard for Care*, came out in December 2003 and really talked specifically about the role of information technology, the critical investments required to bring the standards of care up to the levels that they have to be. You may have seen a study that came out in *The Journal of the American Medical Association* recently revealing that of the people who gave permission for their children with leukemia to enter a randomized trial, only half of those individual families understood what they were actually agreeing to. That is just one tiny sliver of the problem of literacy and understanding. Communication, if it is to be successful, has to be commonly understood by both a sender and a receiver. In health care, we fail to reach that standard.

The report from the IOM on the subject is to be expected in the next three months, depending on the review process.[1] I think that this will help all of our efforts that many of you have pioneered to promote greater awareness and solutions to the problem of health literacy.

What does all this add up to? What are we trying to accomplish? I would like to suggest that a more nearly ideal health system would have six attributes. First, it would begin from a population and ecological perspective. It would understand that health is a community affair as well as an individual affair. It would make proportionate investments to strengthen the environment in which each of us grows and lives, as well as worrying about the individual elements of care.

Secondly, an idealized health system would be one that combines prevention and public health as an integral part of our health care thinking, investment, and strategy. It would have much more than medical care as a foundation for improvement of health.

Third, it would be a system that was universal in its access and available to everyone. It would not have piecemeal

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[1] Editor's note: *Health Literacy: A Prescription to End Comfusion* was released in April 2004.

SIX ATTRIBUTES OF AN IDEAL HEALTH SYSTEM

- Population perspective
- Public health and prevention are integral components
- Universal access
- Patient centered
- Evidence based
- Quality driven

coverage. It would not have unequal treatment. It would be a system that provided for people as individuals and as families.

Fourth, it would be person centered and not provider centered. If you look at the variations in care around the country, which are significant, much of the explanation rests not in differences of patient needs or preferences but rather in differences in the training, information, practice habits, and patterns of care that providers offer. So shifting to putting people first and being person centered would alter the way in which the driver of these decisions becomes the patient, not the provider.

Fifth, it would be an evidence-based system. It would not be a system that derives and celebrates the individuality of personal, anecdotal thinking on the part of providers. Keep in mind that the plural of anecdote is not evidence. The evidence would be the driver of what is done throughout the system.

Finally, it would not be a system that is price driven. It would be a system that is quality driven. I have to say that this is especially true of preventive services. We do not apply the same standard to prevention as we do to treatment. In treatment we talk about cost effectiveness. We are willing to spend money to get some value. In prevention, very often we want to know only how much it saved.

It turns out some preventive measures, such as vaccinations, do save net dollars compared to what we invest. But for other interventions, we may need to invest in order to get benefit. It is worth doing if the payoff is worth the price, just as it is worth treating the acutely sick patient if the payoff is worth the price.

Now let me offer for discussion, I hope a little bit provocatively, 10 ideas for what could be done to really find our way through this. These are my personal ideas and beliefs.

The first, I believe, is we are not going to really solve the big problems if we do not find middle ground politically. I think that from the right there has to be a recognition that there is a social responsibility to provide universal health care insurance. From the left, there has to be a recognition that there is also individual responsibility

10 STRATEGIES TO APPROACH 21ST CENTURY HEALTH CARE

- Find political middle ground
- Pay for prevention
- Put people first
- Fund and deploy an information technology infrastructure
- Use evidence-based guidelines as the presumptive clinical strategy, with justified exceptions
- Ration intelligently
- Insist on transparency
- Experiment with chronic disease care models
- Strengthen partnerships
- Educate for quality

for choices in health and, I would submit, means-based payment for care at all ages, something we can discuss.

Secondly, we have to incorporate prevention into our payment system and our investment for health. We have to put reimbursement for preventive services as an integral part of the benefits package. We have to be prepared to invest in community-based preventive programs, regardless of whether traditionally they have been part of our health care system. I cannot resist adding the tobacco problem, which is still the number one cause of preventable, premature death in the United States and a growing problem around the world.

Number three, which is the whole theme of this conference, put people first. Whose interests are being served, providers or patients? Whose needs are being met, families and children, or manufacturers? Let us get past the idea that it is acceptable to have unequal treatment. It is not. All of us, involved whatever way we are in the health system, as providers, as payers, as grantmakers, all of us have to work to end unequal treatment.

Number four, information technology as an infrastructure from all of the work of the *Quality Chasm* series, including particularly that last report, emphasizes that we must invest in higher capacity for information technology in health care. In the most recent U.S. Department of Commerce study, health care ranked 38th out of 53 industries in its investment in information technology per employee. That is obviously an information intense industry. We have to get over the hump of the necessary investments. I think one idea is a kind of Hill-Burton effort for the information age, a capacity to invest nationally to help institutions put in place the technology which, over time, will save money and will save resources. But there is this threshold need to get over. One way to do it would be to put a little utility fee on every health care dollar and put it back into our information technology. But there are dozens of other alternatives. A key from the national point of view is the importance of standards and performance levels that have to be met by these systems. So that anyone who invests in them will not feel that it is a dead end.

Fifth, we ought to insist everywhere that the presumptive clinical strategy is based on evidence. There can be exceptions, but it ought to be the default that we start with our evidence-based guidelines. Mindless variation is the enemy of quality in health care. You know, John Kenneth Galbraith, the economist, once famously remarked that humility is a vastly overrated virtue. Well, I would submit that physician autonomy is a vastly overrated principle. It is something people believe in, but it is good only as much as it is consistent with the highest quality of care.

Sixth, let us ration intelligently. Yes, rationing is unavoidable. But we must get beyond the unfair ration and face up to defining the basket of services that everyone is entitled to have. Let us permit people, if they wish and can afford to, to purchase beyond this, but face up to the need to ration intelligently.

Let us insist on transparency. The data that hospitals and providers and physicians hold are not theirs. They belong to the public. The public is entitled to know. They are entitled to know the performance, and they are entitled to know the results. This obviously will require a lot of work to ensure that the data are fairly and accurately reported and adjusted properly. But the argument should not be whether to make the data available; it should be how to make the data available.

Eighth, we still need to experiment with models for chronic disease. There are many innovations, community-based programs, management-based programs, excellent models that point to some solutions. We need more. We need programs that will be home based and patient centered that involve active communication and management by teams who are trained and operate as a unit.

Ninth is an old idea that needs to be reemphasized—no sector, no institution can solve the problem alone. We have to work through partnerships. We have to find those alliances of common purpose, with payers, with insurers, with purchasers of care who will pay for quality, who will make access their responsibility. We need to have government agencies as well as foundations supporting innovation. We need to work across all of the professions to bring people together to help solve these common problems.

Finally, whatever we do, I believe, we will not succeed if we do not educate our workforce for quality. We have to have systems thinking introduced in the training of our doctors, our nurses, and our other professionals. We have to emphasize evidence. We have to put in place a capacity to utilize the systems of information technology. We need to alter the culture that puts greater emphasis on team training across the professions in clinical care so that people who have needs will have those needs met.

So with that, and I cannot say more than to reinforce the key message of this conference, put people first.

Resources

Referenced Institute of Medicine reports are available on-line at www.nas.edu.

Insurance Coverage

Insuring America's Health: Principles and Recommendations, January 14, 2004.

Hidden Costs, Value Lost: Uninsurance in America, June 17, 2003.

A Shared Destiny: Community Effects of Uninsurance, March 6, 2003.

Health Insurance Is a Family Matter, September 18, 2002.

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Putting People First: What Foundations Can Do in Mental Health

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State governments, the major historical providers of mental health care, are financially, politically, and structurally unable to meet current demands for services.

I stand before you today as a recovering mental health commissioner. So in my remarks, you may hear a little bit of bias. You may hear a little bit of sarcasm. You may, in fact, hear a little bit of my experiences as a mental health commissioner in the Commonwealth of Virginia, where I have spent the majority of my career.

Having served as the keeper of the keys for 17 institutions for the mentally ill, I have a particular perspective on what is important in mental health and what we need to do at both the national and state level. Certainly I hope that we in the foundation world can begin implementing some of the things that are necessary for people who have a variety of mental disabilities. It has actually been 32 years since I have had much involvement with foundations, although I wrote my doctoral dissertation at Brandeis University on foundations and fundraising as it applied to communities of color and on the interface between philanthropy, race, and mental illness.

Because of these policy failures, persons with mental illness, and related physical illnesses, are failing to receive care.

My aim today is to help funders think anew about the increase in attention and resources that must be directed to correct the dismal status of mental health policy and services in the United States. To do this, I am going to use a variety of sets of data and reports circumscribed around some brief historical material that provides the context for thinking about the future.

I want to start by offering my conclusions. The first conclusion is that state governments, the major historical providers of mental health care, are financially, politically, and structurally unable to meet current demands for services, and the prospects for the future do not look terribly bright. The role of the federal government has been delimited to little more than reimbursement for some of the costs of Medicaid. As everybody here knows or should know, the federal government has not developed a national mental health policy that will move us forward. This position by the federal government, by the way, is not new. It has held since the Pierce veto in 1854.[1] So the federal government has been an unwilling partner in the field of mental health for an extraordinarily long time.

The second conclusion is that because of these policy failures, persons with mental illness, and related physical illnesses, are failing to receive care. They also are not being led toward recovery. They have a higher-than-average risk of relapse; lifelong disability; higher-than-average rates of unemployment, hopelessness, hunger; and

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[1] In 1854, President Franklin Pierce vetoed legislation that would have resulted in the sale of federal lands to subsidize institutions for indigents with mental disabilities.

an extraordinarily high risk of death. Since 1932, persons with a diagnosis of mental illness have had a higher death rate than almost anyone else in the United States. Let me give you an example. When I became commissioner of the Virginia Department of Mental Health in 1990, some state hospitals had no primary care physicians. Persons with mental illness could be patients in many of our hospitals without a medical exam for weeks, sometimes months, sometimes even years. For those individuals who had both a physical illness and a mental illness, the physical illness was very often interpreted in psychological terms. So we had some of the highest death rates in the country in our system. I dare say that Virginia was probably not unlike Colorado or Mississippi or New York or other states as well, where the quality of health care did not match the quality of mental health care.

For foundations, there is an immediate need to provide leadership and support for evidence-based services, practice-based evidence, epidemiological research, outcome evaluation, public policy, public education, and workforce development. The pattern of involvement by foundations over the last 20 years is not adequate for the future.

Virginians are rightfully proud of their history, and they are proud of the fact that the first hospitals in the United States for persons with mental illness were developed in Virginia in 1765. We continue that history. We continue in the United States to place far too much significance and emphasis on inpatient hospitalization of persons with mental illness. That is where we spent the majority of our resources in Virginia. In Texas, where I now live, that is where we spend the majority of our resources as well. This continues to be true in a number of state systems around the United States.

Our historical emphasis continues to influence the course and the direction of mental health care in the United States. Historically, going back to the 1700s and 1800s, we link mental illness with high income. We assumed then, as well as now, that states would have the primary responsibility, not the federal government. We separated individuals with mental illness from their families. We have equated illness with hospitalization, almost to suggest that if you are in a hospital, ergo, you have a mental illness. We continue to operate from an assumption that treatment requires long stays in hospitals. That is not always the case. We link mental illness with dangerousness. We have, in fact, increased the stigma of mental illness. We have assumed that mental illness is, in some respects, the fault of the person or some reflection of immorality. We have concluded at different times in our history that race insulated groups from mental illness. Then we swung very much to the opposite direction, in particular, to focus on African Americans and Indians. We saw men as being more at risk than women.

State mental hospitals became the primary economic base of many communities. In the 17 Virginia communities in which I operated state mental hospitals or hospitals for the mentally ill and mentally retarded, it was very clear that the hospital was, in fact, the largest business in town. After a period of time, I stopped referring to our

Regrettably, there is a disconnect between health and mental health.

hospitals as service providers. Why? Because I noted that with a budget of $700 million a year and 17,000 employees, we were the fifth largest business in Virginia. We operated the largest pharmacy in Virginia, the largest laundry in Virginia. The economic impact of those 17,000 employees was extraordinary in small communities.

So you can imagine what happened in my state when we started discussing that some of those state hospitals ought to close. When you are the largest employer in town, to discuss closing a state hospital becomes a political issue.

Regrettably, there is a disconnect between health and mental health. So that is part of the history. We saw a shift in 1993 when about 43 percent of all care was then provided in state hospitals, as opposed to in the community. Since then, state hospitalizations have declined as community care increased. Those trends have continued.

Mental illness accounts for 15 percent of the burden of disease in this country. It is a far more important source of the burden of disability than cancer.

Let me direct your attention now to six important reports.

- the Surgeon General's 1999 report on mental health (*Mental Health: A Report of the Surgeon General*);
- *Mental Health, United States, 2000*;
- *Mental Health: Culture, Race, Ethnicity, a Supplement to the Surgeon General's Report on Mental Health* that came out in 2001;
- the World Health Organization (WHO) report from 2001, *Mental Health: New Understanding, New Hope*; and
- the Grantmakers In Health report, *Turning the Tide: Preserving Community Health Services.*

Then I want to spend more time talking about the report of the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America.*

There were a number of very important points from the Surgeon General's report from 1999. Most important was that it was the first time in the history of the United States that a Surgeon General issued a report on the issue of mental illness. The report highlighted some compelling statistics. Mental illness accounts for 15 percent of the burden of disease in this country. It is a far more important source of the burden of disability than cancer. In fact, it ranks second in the burden of disease in most market economies around the world. Depression is the second leading cause of that disease burden. Fully 16.4 percent of the U.S. population has an anxiety disorder, 7 percent has a mood disorder, and 1.3 percent has schizophrenia. Perhaps the most extraordinary statistic was that approximately 21 percent of the United States population has a diagnosable mental illness. The report noted that a little bit less than half of those populations with a diagnosable mental disorder were receiving any kind of mental health treatment.

Rates for racial and ethnic minorities were also compelling. For example, the prevalence rate was even higher for African Americans in some areas. On the other hand, the rates for Hispanics were noted to be very similar to those of Anglos. At that time, we had virtually no studies that were reliable on the rates of mental illness in Native American populations. We still do not in 2004.

The rates were difficult to measure for Asians. Asians are often referred to as the model minority, suggesting that they do not have the same problems as other racial and ethnic minorities. But if you talk to persons such as the late Evelyn Lee, from San Francisco, she would tell you that if you ask questions in English, the Chinese will respond in Chinese. You will not be able to understand whether they have the illnesses or not. Language differences were significant. So the statistics do not provide an opportunity to understand them.

Now, when I go through these points, I hope that you will begin to think about whether or not there is a place or opportunity in some of these areas for specific foundation activities.

When I get to the end, there is going to be a long shopping list of more than 50 possible items [see box]. This is a compilation of the things that I will say in process. As I go through, I hope that I stimulate some additional thoughts on your part about some of the areas that foundations can begin to consider.

The Surgeon General's report from 2001 was extraordinary, and a first, since no Surgeon General in history had ever taken the time to talk about the connections and the interconnections between culture, race, ethnicity, and mental illness. Part of what was reported, contrary to the information that we have had for almost 230 years in the United States, was that the overall rates of mental illness seem to be constant. There really was not much difference in the frequency of severe mental illnesses and some others by race or by population groups or by income or events or economic changes or elections and, dare we say, political parties. Mental illness could care less about being Democrat or Republican or independent or agnostic. It did not seem to matter in terms of what was there.

But there were disparities. Minorities had less access to an availability of mental health services. Minorities were less likely to receive mental health services. Minorities in treatment oftentimes receive poor quality of mental health care. Minorities are underrepresented in mental health research.

These are key areas for us. We should ask, "Why does this occur?" Some say that this is a clear indication of racism. I would say no. It raises other kinds of questions. So let me give you some ideas.

One of the things that we found in working together with four communities of color (African Americans, Asian Americans, Hispanics, and Native Americans) over the last 10 years was that what all of these populations share is that they come late for service. I do not mean by the clock but in the history of the disease.

African Americans, Native Americans, and Anglo populations are a little bit different in that regard. Latino populations and the Native American populations delay for years when they go for psychiatric care. When they finally receive services, indeed, their particular problems have become chronic.

One of the things that we can do is to look at that as a negative, or we could say that these communities have what we call elastic boundaries. There are strengths in those communities that allow a Native American community to keep within their midst a person who may be symptomatic. So it suggests that maybe we need to learn a whole lot more about what those strengths are in those communities that allow them to manage severe mental illness without some disruptions for longer periods of time.

If you look at inpatient admissions in the United States for all hospitals for all groups, about 593 persons per 100,000 find themselves in a mental hospital or an inpatient residence of some kind. But as you start to look by racial group and by type of hospital, there is tremendous variation. For African Americans, the rate is 931 per 100,000. For you statisticians, that is one or two standard deviations above the mean. If you ask within the population of African Americans to look at men between the ages of 18 to 35, the rates would be 1,300 per 100,000. For Native Americans, the rates were 818; for Asian populations, as I mentioned, below the mean, 268; for the Hispanic populations, a little bit below the mean; and for white populations, about 550.

In terms of involuntary commitments by race (we only have data on black and white for the great state of Florida), the rates are 4.8 African Americans for every 1 white person who is involuntarily committed. So, again, it raises the question of what factors account for these disproportionate statistics.

If you go back and think about something that I said earlier about some of the rates from 2000 or 1999 and the constancy of those rates throughout the world, part of what we find is that there really is not very much variation in the mean. So if there is not very much variation, what accounts for this extraordinarily high rate of involuntary commitments? I think part of it has to do with the culture within those communities, and it has to do with the structures and the systems that we have created.

The WHO report, another one of those extraordinary reports, finds that in the world, about one in four families has a person with mental illness, and families carry the major burden of mental illness. If we talk among our own relatives, we begin to find, as well, that that is true. The burden of families is seen in the impact of mental illness on their work, on their income, on their sense of fear, on their sense of comfort, on their achievements, and on interfamily relationships as well. Obviously, mental illnesses are universal. The WHO report pointed out that:

- Mental illness is the major cause of disability worldwide, and the burden of severe mental illness is increasing rapidly.
- Depression is the primary cause of most disability, accounting for about 12 percent of the disability worldwide.
- Overall, mental illness accounts for about 31 percent of disability.
- Twenty percent of the patients are found in primary care settings. The most common diagnoses in primary care are depression, anxiety, and substance abuse.
- Mental illness is influenced worldwide by poverty, sex, gender, age, disaster, and physical disease.
- Depression is found more commonly in women.
- Mental illness consumes about 2.5 percent of the gross domestic product in the United States.

- There are significant differences by gender in terms of suicide. Where the rates are 15 per 100,000 worldwide, the rates for males are a lot higher, 24 per 100,000, 6.8 per 100,000 for women.

We do not understand much about these statistics on suicide. I would dare say we do not understand much about young white males in the United States and their angst or their depression. We do not understand what the linkages are between Columbine and depression.

We need to ask more questions. I think there are ways that we could begin to ask some of those questions through the resources and the opportunities for foundations.

If you have not seen the President's New Freedom Commission report, you really should. Almost every president, going back to Truman, has had some kind of national effort to develop new knowledge or new approaches or new policies in the mental health field.

I dare say this is one of the most extraordinary reports ever. It raises fundamental questions about mental health in the United States, and it exercises a challenge for public mental health systems all around the country. So I want to spend a little bit more time and give you some of the details because I think they reflect some the dialogue that I hope we will have about the role, the prospective role, of foundations.

Achieving the Promise reflects the vision of probably hundreds of people who participated in the development of this report. Their vision and the vision agreed to by this administration was that the federal government would lead the effort to transform mental health care in the United States. No other president, no other report I have seen, has taken on that level of effort or vision. Extraordinary reports have come before: the Carter Administration's report was significant; John F. Kennedy's report was significant; Eisenhower's was significant; and, certainly, the Truman report was significant. But there is something different about this report that I will try to illustrate. One of the things is that President Bush has asked the nation to make a commitment to persons with mental illness. Part of what I think the report is attempting to address is the continuation of stigma. Part of what the commission found was that we really have not progressed very much in terms of the quality of mental health care that is provided to people in the United States.

Bush has said that Americans with mental illness deserve a health system that treats their illness with the same urgency as psychical illness—parity. But the parity bill has not passed. We are not even close in terms of being able to have parity between health problems and mental health problems.

So from the very start, as the president starts to outline this particular vision, we ought to raise significant questions about implementation. How do we get from point A to point Z in terms of mental health?

Again, I think it is important to put it in historical context. We have been asking these questions in some regard since 1765, and we have asked them with almost each successive administration. Remember, part

The [New Freedom Commission] found three obstacles that had to be overcome: stigma, fragmented mental health service system, and unequal treatment and dollar limits for mental health care in private health insurance.

of what I talked about earlier is that state governments have taken on the responsibility for mental health care in the United States, not the federal government. Really, the only things that the federal government has operated are mental health units in VA hospitals and, at one time, St. Elizabeth's Hospital for sailors and seamen in Washington, DC.

So we really have to ask the question, if we intend to transform the system, if we expect to have parity between health and mental health, if we expect to do away with this historical mind-body dualism, how do we get there?

The president and the commission found three obstacles that had to be overcome: stigma, fragmented mental health service system, and unequal treatment and dollar limits for mental health care in private health insurance.

As for stigma, nobody really wants to talk about a family member having mental illness in the United States. If you are one of the four groups of color in the United States, it is something that we do not do. You do not find many of those groups standing up before a body such as this and saying, "I want you to know that my son or my daughter has a mental illness." It is kept within the community. It is kept within the family. So stigma remains for us a significant factor. If that is to be overcome, how do we get there? The federal government has been funding the *Eliminating Barriers* initiative, a media-based project, for about a year. It is designed, for the most part, to bring before the public a variety of mechanisms to eliminate stigma against persons with mental illness, a major barrier to care and recovery.

So how do we do it, with the fragmented mental health system that we have? Keep in mind, again, that we are talking about states. There has been, since the 1700s and 1800s, this question about states' rights. Does the federal government have the right and the responsibility and the power to get states to change the way that they do business? In addition, in many states, the continuation of the old programs has economic and political implications. I was hung in effigy in many places in Virginia because I dared talk about closing state hospitals in rural communities. We do not undertake this lightly when we talk about a fragmented mental health system. We are talking about fragmented states and how it is that we can convince state governors and legislators to begin doing something about that.

The third of those barriers talked about in the report is unequal treatment and dollar limits for mental health care and private health insurance. We still are not there yet either.

So the question for foundations is: Is there a role for us? Is there something that we can do individually, collectively in our states, or perhaps nationally to address these issues?

These were the major areas of focus within the president's commission. There were also many subcommittees on everything from acute care to suicide prevention, children and families, consumer issues, co-occurring disorders, criminal justice, cultural competence, employment, and income support. By the way, there is not much here about workforce development. There was not much attention that was paid to how it is that we are going to develop the workforce for the future or provide continuing education to those already in the workforce.

The president's commission said that Americans need to understand that mental disability is not a scandal, it is an illness. But how do we do it? How do we get that across? Like physical illness, it is treatable. But who believes that, especially when the treatment comes early? What is the implementation strategy? How do we get there? What are the steps? Where is the plan? Where is the strategy?

So the president and the commission put forward a vision of a future in which everyone with a mental illness would recover. This is an extraordinary vision, an extraordinary goal that mental illness can be prevented or cured, detected earlier, and that everyone of all ages with a mental illness will have access to effective treatments and supports that are essential for their living and working and learning and participating fully in the community. The question is again, how do we get there?

The report also puts forward a vision of services and treatments that are consumer and family centered and that are not focused on bureaucracies. I am a professor in a university and have been so for 30 years. I can tell you that consumer- and family-centered care are not part of the course and the content of most of the training programs. Training is very much geared towards the systems, towards the employees, towards the workforce, towards the production of therapists and the like.

How much do we want to lend or to give over the power for decisionmaking to consumers and families? I think, in part, there are some contradictions and barriers that we have to overcome. We want to provide real and meaningful choice in treatments and providers to family members and consumers.

Lots of principles underlie the transformation, including promoting consumers' ability to manage life's challenges successfully. Throughout the United States, there are very few consumer groups that have the financial wherewithal to maintain operations. There are some new groups that have developed in the last two years. A Native American group is just forming; in fact, they met in Minnesota this summer to try to develop a national organization of Native Americans interested in mental health. They struggle for dollars and support. The Asian group that is housed in Denver, Colorado, is doing very well but struggles for dollars. The Latino group, the oldest of all the groups in terms of consumers and family members and others, has struggles as well. The African-American group, that I chair, struggles for dollars, for resources, and for support.

Four of these groups, by the way, have formed a national association of groups of color attempting to do something collectively. Other than some resources that were provided by The Annie E. Casey Foundation, we struggle for support. So it raises lots of questions again about, how do we get there?

Americans need to understand that mental disability is not a scandal, it is an illness.

These are the six goals in the president's commission report. These are part of the vision. This is where we would like to be in a few years, in an ideal sense. That Americans understand that mental health is essential to overall health. That mental health is consumer and family driven. That the disparities in mental health are eliminated. Other goals include early mental health screening, assessment, and referral so that services become common practice. Excellent mental health care is delivered, and research is accelerated. Technology is used to access mental health care and information.

On the technology access point I would ask, by whom? For the most part, many of the persons with mental illness, particularly the lower income and the populations of color, do not have access to technology. So how do they do that? How do we make sure in communities that these populations have a greater chance of being able to access services if, in fact, they are neither computer literate nor do they have access to computers and they do not trust technology? How do we do that?

I will try to address very quickly some of the goals and some of the things that will happen if the goals are not achieved.

So in the first goal of getting Americans to understand that mental health is essential to overall health. If we fail to establish mental health as a priority, what will happen? We will maintain a two-tiered system with 30,000 suicides annually, without access to services, and that mental illness might, in fact, be a leading cause of disability, school failure, incarceration, homelessness.

If you look at financing, you continue to see a disproportionate amount of the dollars are public dollars. Twenty percent of the dollars come from state governments, a significant amount comes from Medicaid (20 percent), and 13 percent from Medicare. The trend, by the way, is for increasingly larger amounts of money from the public sector. If I had shown you this chart in 1970, most of this would have been state money. If I had shown you the chart in 1940, it would have been 88 percent or 90 percent state money.

Suicide is the leading cause of violent deaths worldwide, 49 percent of all of violent deaths worldwide are from suicide; 32 percent homicide; and war related, 19 percent. To achieve the goal of mental health awareness is to advance and implement a national campaign to reduce stigma. Again I would ask the question of how.

To achieve the goal of mental health care becoming consumer and family driven, we need to develop an individual plan of care for every adult with a serious mental illness and every child with a serious emotional disturbance. If you talk to the people who operate community mental health centers in the United States, most of them will tell you that they have extensive waiting lists already, and that it is almost impossible for them to get to the persons that they want to under the present conditions.

By the way, I am not a skeptic about those things. I think it is certainly possible, but I think we have got to have some strategies. Involving consumers and families and fully orienting the mental health system towards recovery is a struggle. The consumer movement is, in part, stuck. The family movement at times is stuck. If you go to any of the meetings of the National Alliance for the Mentally Ill (NAMI), where I try to go every few years or so, that audience is predominantly Anglo, disproportionately Anglo. NAMI has tried for about 30 years to increase the participation by populations of families of color.

How do we do that? What do we know about how those families conceptualize the problem of mental illness? What do we know about how they get involved in health care or in mental health?

Part of what the president's commission talks about is those key challenges, closing the 15-year lag, the time period that it takes new discoveries to reach practice. That is extraordinary. What it suggests is that at different periods, in the delivery of mental health services, new knowledge may be 12 to 15 years behind. In a meeting that we held at the Hogg Foundation recently with an outstanding group of psychiatrists and psychologists and pharmacologists, one of the leading research psychiatrists in the United States suggested that we will not see much change until the current crop of psychiatrists has died or retired.

I am going to let that sink in for just a minute. We will not go very far until we get this extraordinary change in terms of new knowledge in the field. We need to harness the power of health information and identify better ways to work together at the federal, the state, and the local levels, better coordination, focus on quality outcomes, and the like.

The primary strategy that comes out of the president's commission report is the development of a state mental health plan. That was the case with the Carter plan. If you talk to others, they will tell you that that was the case in the John F. Kennedy plan and that was the case, to some extent, in the Eisenhower plan and the Truman plan. So the question becomes again, how do we develop and implement these kinds of strategies?

Now, I wanted to go where foundations are. I have a pretty extensive shopping list for you that suggests all of the materials that I shared with you. I would strongly encourage you to go back to the reports I have referred to here. So what is it that foundations can do? One of the things that we can do is to focus on the health and mental health interface. We can assist in eliminating this barrier that has been around for a long period of time. I think it is almost a disaster for us. It raises significant questions for us as to whether or not we ought to support the movement and the shift of mental health into the primary care sector. It might be very interesting to look at some pilot projects around the country for that.

Second, we can also assist in the transfer of knowledge. This 12- to 15-year gap in the movement of knowledge, how can we solve that? How can we make it much less? How can we get knowledge transferred in five years? How can we use technology in some very creative ways to get at some of those issues?

Number three is supporting workforce development. As you probably know, the National Institute of Mental Health, the Substance Abuse and Mental Health

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Services Administration (SAMHSA), and some others have basically moved away from the support of students and training in psychiatry, nursing, social work, psychology, and related fields. Is there something that foundations can do to support workforce development that is not being done now?

We also need to support studies on stigma reduction. Stigma continues to be not just one of the three that I mentioned early in the president's commission report but one of the most extraordinary of all the things that are happening. We need to support those four communities of color that I mentioned earlier in terms of the development of their consumer organizations.

We need to examine the usefulness of state hospitals, of which we have had very few in the way of studies. We still have 220 state hospitals in the United States. Do we need them? Do we need a model that was created in 1765 and has not changed very much? How do we get out of this economic morass that we find ourselves in? How do we offer to state governments an alternative to the state hospitals? How do we address the concerns of local communities about the economic impact on their communities if, in fact, we do that?

We need a study of the national recidivism rates by race, by community, by population as well. We need a major study of cultural competence. We talk a lot about cultural competence, but there has not been a national study. We do not know a whole lot about some of the elements of cultural competence. The federal government is, in fact, not willing to put in the dollars to do part of that study.

We need employment projects for persons with severe mental illness. The highest rates of unemployment among Americans are persons with a severe mental illness diagnoses.

We need much more information on studies on how communities interpret and receive information by race. Do we really know how the Korean community receives information about schizophrenia? Do we really know much about how the Hmong population receives information about mental illness? Do we know much about how Latino populations receive information about mental illness? Then the next question is what do they do with it? Does the information have an impact?

We need to study and understand much more about the role of churches, the parity issue, and the implementation of the New Freedom Commission report. We need to understand a whole lot more about transformation strategies in states, co-occurring disorders. We need to understand studies of race and suicide.

We need to understand medication compliance. If, in fact, we are moving rapidly, as we are, towards medication as the premier way of interfacing with persons with mental illness, what about those persons who do not take their medication? Do we understand that very well?

We need to understand the resistance to cultural competence or the use of alternative medicine. We need to understand much more about voluntary participation in mental health by race. Why is it that very few Latino families or African-American families or Native American families participate in NAMI or the like? We need to understand more about inpatient hospitalization, the utilization of technology, and lots more.

I would like to end with this extraordinary opportunity that is available to those of us in foundations. Foundations are organizations that can take and, to some extent, precipitate calculated risk. That is why I ask that every one of us in our foundations considers setting aside 5 percent to 10 percent of our resources in this particular area.

I would suggest that we become very involved in expanding within Grantmakers In Health the group that seeks to address the problems of mental illness, that we, in fact, create a national movement that really begins to address some of the issues.

I would suggest that we take on as foundations in the United States, this effort to implement the most significant parts of the president's commission report.

I would end by putting it again in historical context. In 1765 we had this same discussion about how to manage the problem of mental illness with all of its attendant characteristics of dangerousness and misunderstanding and the like. With almost every decade since then, until this very day, this very hour, in this very place, we continue the dialogue. I think that is a tremendous challenge and a tremendous opportunity for those of us in foundations.

It is very clear, if you go back to my conclusion at the start of this. State governments cannot do it. The federal government perhaps is unwilling to do it. But before us in this last report, we have, at least in my estimation, the most extraordinary statement of vision that we have ever had in this period of time.

WHAT CAN FUNDERS DO?

Following are recommendations for health grantmakers to examine when setting funding priorities and making funding decisions:

1. Focus on the interface between health and mental health.
2. Assist in lowering the time lag in transferring knowledge into practice.
3. Support workforce development.
4. Support studies of stigma reduction.
5. Support development of consumer organizations addressing needs of racial and ethnic minorities with mental illness.
6. Support studies of families of color.
7. Support doctoral researchers.
8. Support a national study of state hospital utilization.
9. Support a national study of recidivism by race.
10. Support efforts at the intersection of juvenile justice and mental health.

WHAT CAN FUNDERS DO? (CONTINUED)

11. Focus on children's mental health.
12. Support a major study of cultural competence.
13. Fund employment projects for the severely mentally ill.
14. Study the use of information sources by race.
15. Support a national study of the mental health needs of Native Americans.
16. Support development and dissemination of evidence-based practices.
17. Develop knowledge on help-seeking behavior by race.
18. Explore the role of churches in mental health.
19. Consider mental health parity approaches.
20. Help with implementation of the New Freedom Commission report.
21. Work on transformation strategies in the states.
22. Interpretation of project support.
23. Focus on the design of health insurance and mental illness.
24. Study the accuracy of diagnosis by culture/race.
25. Study involuntary admissions by culture/race.
26. Look at immigration and mental illness.
27. Fund strategies for addressing co-occurring disorders.
28. Consider implications of shifting mental health to the primary care sector.
29. Study race and suicide.
30. Support conceptualization of the severely mentally ill by race.
31. Support work on medication compliance.
32. Provide support for projects to boost physician adherence to protocols.
33. Look at relationships between cultural competence and licensure.
34. Consider resistance to cultural competence.
35. Explore uses of alternative medicine.
36. Fund work on the relationships between depression and welfare intervention.
37. Examine voluntary participation by race.
38. Fund studies of inpatient hospital utilization.
39. Support work on decisionmaking factors by culture.
40. Examine police tactics and interaction with the severely mentally ill by race.
41. Fund training of police and sheriff officers.
42. Investigate deinstitutionalization and race.
43. Address problems of housing of the severely mentally ill by race.
44. Support development of national policies.
45. Fund work on the health status of the severely mentally ill.
46. Explore uses of technology in mental health.
47. Increase the number of researchers of color.
48. Place a higher priority on funding gap-filling research.
49. Create research training opportunities.
50. Foster professional and career development of researchers.
51. Look at federal and private support of research.
52. Consider how to promote community-based research involvement.
53. Share findings with communities of color.

Selling Sugar and Fat: What the Ad Industry Is Telling Our Children

Marion Standish, The California Endowment
Mary Story, Ph.D., University of Minnesota
Jerome Williams, Ph.D., University of Texas at Austin
Margo Wootan, D.Sc., Center for Science in the Public Interest

> *A typical child views about 40,000 television ads each year…. the vast majority of these ads are for candy, cereal, soda, and fast food.*

This afternoon we will be talking about what the food and beverage industry is telling and selling our children. How is it affecting their health? What can we as funders do about it? Food advertising is so ubiquitous that we barely notice it anymore. Food and beverage messages used to be the province of our kids' Saturday morning cartoons. But those days are long gone, and we see these messages on radio, in our schools, in our child care programs, on the Internet. They will soon be very actively on digital television.

The interactive techniques that are available are making the process of integrating advertising with content virtually seamless. Toys and products carry product logos, and food and beverages have become props in movies and television shows. Our neighborhoods are filled with billboards, and in some places, fast food restaurants are the only place where you can buy food. The ads our kids see have co-opted many of their favorite characters, from Sponge Bob to Scooby-Doo. Food and beverage advertising has saturated both ours and our children's environments.

A recent report, released by The Henry J. Kaiser Family Foundation, showed that a typical child views about 40,000 television ads each year. That's just on television—it does not include what they are seeing on the Internet, in school, at the movies, or hearing on the radio. Of course, the vast majority of these ads are for candy, cereal, soda, and fast food.

More importantly, the report notes that exposure to advertising plays a significant role in encouraging food choices and purchases. Those of you who are parents do not need a study to tell you that as you walk with your five-year-old, or even your 15-year-old, through the food aisle or any other place where you would buy food, they are strongly influenced by advertising. In fact, the recent data suggest that these ads to our children are influencing about $500 billion in purchasing power.

Why do we care so much about this issue? According to the Centers for Disease Control and Prevention, the proportion of children between the ages of 6 and 11 years who are overweight has doubled over the last 20 years. In our lifetime we have seen this crisis evolve. The rate for adolescents has tripled. Among children of color, the rates are even higher. Four out of every 10 Mexican-American and African-American kids between the ages of 6 and 19 are overweight. These skyrocketing rates of obesity are contributing dramatically to the increasing rates of Type II diabetes—a disease we have historically seen in adults only. One of every four babies born in California today will develop diabetes. The costs associated with this are staggering. The burden on our children, our communities, and our health care system is truly overwhelming.

The scientific literature suggests that the high prevalence of overweight and physical inactivity is caused by a number of environmental factors. These range from limited access to healthy foods in low-income neighborhoods and poor infrastructure for physical activity in schools and neighborhoods to limited compliance with physical activity mandates and lack of funding for these kinds of programs. Of course, there is also the dramatic and massive increase in advertising and marketing of junk foods to children.

Many questions remain about the effect of food and beverage advertising on childhood obesity. Beyond individual choices, how strong is the relationship between the way food and beverages are marketed to kids and the rising trends in obesity?

In June 2003, The California Endowment hosted a meeting to discuss food and beverage marketing practices aimed at children. We hoped to explore the potential points of intervention and strategies for improving children's nutrition and physical activity environments. We tried to develop some key recommendations and strategies for what funders can do. The presentation today was part of that discussion, and it was such an important meeting that Grantmakers In Health felt it was worth sharing with a wider group of funders.

Our panel will help us unpack the complex issues of marketing and advertising junk food and soda to kids and its impact on their health, and help us think about what we as funders can do about it. Our first speaker will be Mary Story who will discuss the state of the research on the relationship between media and behavior. Following her is Jerome Williams, who will illuminate for us how and why the food and beverage industry targets its efforts to communities of color and its impact there. Our final speaker, Margo Wootan, will highlight public policy opportunities at the local community level, the state level, and the national level that many of us could get involved in.

Mary Story, School of Public Health, University of Minnesota

My comments today will address what is happening in the United States, but this is actually a global issue. For the past year, McDonald's has had billboard ads in The Netherlands and Austria to display what looks like an infant nursing; in fact, the infant is sucking on a sesame seed bun.

Food manufacturers in this country spend millions of dollars on food advertising every year. *Advertising Age* estimated that in 1998, about $1.6 billion was spent advertising for just candy, snacks, and soft drinks. When you look at the ad spending just last year in the United States for companies in specific products, the figures are dramatic. Just for M&M candies, it is $67 million. Mountain Dew, which is marketed primarily towards teenage boys, spent almost $70 million on advertising.

Now compare this with the annual National Cancer Institute budget for the *5 A Day* campaign, which focuses on increasing intake of fruits and vegetables. Their nutrition education budget is $1 million. McDonald's budgeted $500 million for its *We Love to See You Smile* campaign. You can see that things are really lopsided.

Marion Nestle reports that the U.S. government's entire budget for nutrition education for children is one-fifth the advertising budget for Altoids mints. Something is wrong.

The amount that is spent on advertising to children has substantially increased. Today's youth are the target of more marketing efforts than ever before, with the advertising industry spending an estimated $2 billion a year on advertisements targeting children. This is a twentyfold increase from 1990.

Why are youth being targeted? They are targeted because they represent three different market forces. One, they are a primary market. They spend their own money. Secondly, they influence their parents' spending. Three, they are a future market. They will spend money in the future. So they represent both a short-term and long-term investment. The heavy marketing to youth is driven by the desire to build brand awareness, brand preference, and brand loyalty, starting at an early age.

Now, the second point: they are an influence market. This is important because marketers know that young children have considerable purchase influence with adults. Marketing campaigns are now designed specifically to get kids to nag their parents. This is called pester power or the nag factor. This quote is from *The Wall Street Journal* by a senior brand manager at Heinz:

> All of our advertising is targeted to kids. You want that nag factor, so that seven-year-old Sarah is nagging mom in the grocery store to buy funky purple. We are not sure Mom would reach out for it on her own.

Multiple food advertising and marketing channels are being used now. Television advertising is the main medium for reaching children. More than 75 percent of the food advertising budgets and 95 percent of fast food chain budgets are for TV. With the average child in the United States watching about three hours of TV per day, children are viewing about 20,000 to 40,000 commercials annually. Food is the most frequently advertised product category on children's TV and accounts for about 50 percent of all ads targeting children, so that children view about one food ad every five minutes. The average child in this country views between two to three hours of food ads every week.

We did a study a few years ago looking at what food was advertised on Saturday morning children's TV. We had a graduate student record for one month all of the different channels of food ads. Take the USDA food guide pyramid. The tip of the pyramid is in red. That is for high fat—for fats, oils, sweets. If you reconstruct the pyramid reflecting ads seen on Saturday morning TV, over half of the pyramid is in red. More than half of the foods advertised were for foods that were in the fats, oils, and sweets group. Fruits and vegetables are

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not even referenced on Saturday morning TV. Other studies have shown that 95 percent of the foods that are advertised on TV are for high-fat, high-calorie, and high-sugar foods.

In-school marketing has also increased. Vending machines are now in almost all high schools. In one school in Minnesota where we did a study, there were 22 vending machines. The vast majority of foods that are in vending machines are for high-calorie, high-fat, and low-nutrition foods.

School cafeterias are pretty much unregulated as far as the foods offered a la carte. School stores can resemble mini convenience stores. Some schools have advertising on school buses, such as this bus in Colorado Springs for 7-Up. You will see corporate name logos on scoreboards and banners. Textbook covers with ads are given free to students. One such company, Cover Concepts, says in its marketing literature, "Places your brand directly into the hands of kids and teens in a clutter-free environment." You can buy class folders and notebooks with advertisements on them. School fundraising also is common with such products as Krispy Kreme doughnuts. Fast food restaurants are now strategically placed in close proximity to high schools.

A recent trend among food companies is to market toys and products with brand logos to preschoolers and young children to try to develop an early brand relationship with the child. You can see soft drink logos on baby bottles, Barbies with brand logos. There is a Little Debbie Barbie, and even a Jell-o Barbie who comes with her own special pink Jell-o. You can buy McDonald's playsets. Play-Doh comes packaged like Oscar Mayer Lunchables. There are also games such as Fisher-Price's Oreos and Teddy Grahams games. These are for toddlers.

Then there is also this trend with counting books. I went on Amazon.com, and I found 40 children's brand-name food counting and reading books. You pay for these, and they are just ads for the products. There are more advanced counting books using products as well. Again, all of the pieces in the books are directly for the food product.

There is an increase in contests and sweepstakes directed to kids that exploits kids. It says they are going to win instantly, which is really appealing to kids, when that is not likely at all. Some contests specifically state that to win you have to be 17 years old or younger.

Increasingly, the on-line media also has more advertising. Almost all of the major food companies have created their own Web sites, which are designed as branded food environments for children. One example is Planet Twinkie. These are highly entertaining, animated, interactive sites, specifically designed for preschoolers, children, and teenagers around their product. They offer games, e-mail, and e-mail cards. In one game on the Oreo site, the food product becomes the pieces in the game.

What is critical to this discussion is whether food advertising and marketing have any influence on what children eat or their weight status. There was a recent exhaustive review of the literature done by Dr. Gerald Hastings at the University of

Strathclyde in the United Kingdom. Dr. Hastings and his coauthors found that children's food promotion is dominated by TV advertising. Most of the foods advertised are presugared breakfast cereals, soft drinks, sweets, snack chips, and fast foods. All of these revolve around the themes of fun and fantasy. There are few ads for healthy foods.

They looked at the effects of food promotion on children's food preferences and behavior. They actually found 65 well-designed experimental and observational studies. They found that the evidence is very strong that food preferences are influenced by food marketing and advertising. Food preferences in children increase for the food being advertised. They also found very strong evidence in the research that purchase-related behaviors are influenced by food marketing. In experimental control studies, food purchase requests by children increased with exposure to the food being advertised. They also found that parents were more likely to report purchasing the foods that were advertised.

Now, with actual food consumption, they found a modest effect, and that is because there have been relatively few studies that have been done looking at actual food intake in relation to food marketing and advertising. Most of those studies were done in the 1970s and 1980s. We know, however, that food preferences are increased by advertising and marketing, and purchase-related behaviors by both children and by parents are increased. So it is likely, then, that if they are buying it, they are eating it.

I think it is important to point out that this research, which focuses primarily on TV advertising, may understate the effects that food promotion has on children. When you see how ubiquitous the marketing is, the effect is likely to be even greater since promotion is in so many different media and channels.

Lastly, the new joint report by the World Health Organization and the UN Food and Agriculture Organization looked at the strength of research evidence that links diet and lifestyle factors to obesity. The report looked, again, at the literature and found four levels of evidence: convincing, highly probable, probable, and insufficient data. The heavy marketing of energy-dense foods and fast food outlets to children was put under the probable category. That is, the research suggests that it is highly probable that heavy marketing of foods to children is related to obesity. The research really, I think, is strong that food advertising is influencing children's diets. Moreover, with more advertising being targeted to low-income children (and low-income children are more likely to watch more TV), their exposure will be even greater than that of other children.

Jerome Williams, Department of Advertising, University of Texas at Austin

As a marketing professor, I focus on research on marketing activities directed toward lower income and, often, minority children. It is important to understand the nature of the beast. It is fundamental to understand that marketers do what marketers do. They look for attractive markets and go after them. That is the

The evidence is very strong that food preferences are influenced by food marketing and advertising.

If you look at Web sites of various beverage companies and food companies, you will notice a high degree of targeting to minority consumers.

fundamental premise that you need to understand in order to cope and deal with these situations.

If you look at Web sites of various beverage companies and food companies, you will notice a high degree of targeting to minority consumers. In addition, a lot of times, you will see targeting going on at the neighborhood level; for instance, KFC boasts about the flavor of neighborhoods. In one particular study, they found out that this ethnic twist can boost sales a minimum of 5 percent to 10 percent. So you can see many times how marketers will gravitate in this direction.

We are doing a study right now focused on the neighborhood. We are looking at scanner data from a number of retail outlets and can match it up with the consumers. So we know for a two-year period everything that is being purchased by particular households in more than 30 stores in this food chain. What we are also able to do is to draw a half-mile radius around each store and look at the demographic composition of the area. So, for example, for five particular stores, we know that about 90 percent of each store's clientele is white. We can also look at other stores where there is a larger ethnic minority population and we can compare the consumption patterns across the various stores and across various neighborhoods. We divided the sample up into those who tend to buy organic foods and those who tend not to buy organic foods. We looked at their purchases for a two-year period across all kinds of food categories such as sweets, poultry, and all other kinds of foods.

When you look at ice cream and cake, the nonwhite/nonorganic consumer tends to spend a much higher percentage of their food budget on these kinds of products. We are beginning to look at other categories such as beverages, sugar beverages, and so forth.

If you look at the percentage of advertising to sales across industries, you find that, two years ago, sugar and confectionery products ranked sixth at 12.7 percent of sales. That is really significant when you think about it. Of 200 industries, most are spending 2 percent to 3 percent of their sales on advertising. But the sugar and confectionery products category was at 12.7 percent, and beverages at 7.4 percent, well above the average for the 200 industries that we studied.

Getting back to the nature of the beast, why is it that marketers go in this direction, particularly in terms of focusing on minority consumers? There are three things that we try to identify. We call them the three Ps. Are there enough **people** in the market? Do those people have **purchasing power**? With the purchasing power that they have, do they have a **propensity to spend** it on certain types of product categories?

We know marketers look at the ethnic minority market, and they know that there are a lot of people there. For instance, currently, 12.4 percent of the population is African-American, and about 13.5 percent is Hispanic. When you add in other ethnic minority groups, you are up to about one-fourth to one-third of the nation; and in many counties and cities around the country, it is much greater than that.

Next, they look at the size of that population, and they say, "Well, what is the purchasing power?" Currently African Americans have about 8.5 percent of the buying power in the country, Hispanics, about 7.6 percent. If you add all of that together, African Americans are close to $600 billion, and Hispanics are close to $400 billion, you are talking about $1 trillion in purchasing power.

The third P is are they willing to spend it on the products that are marketed? If you look at some of the government data, the market basket of what people spend their money on, and you look at the food category, white consumers tend to spend 13.3 percent of their budget on food, whereas black consumers spend 14.8 percent, and Hispanic consumers spend 16.4 percent.

So the marketers note that these consumers are overspending in terms of percentage of their market basket purchases. Further, we looked at many different product categories. I studied three categories: regular carbonated soft drinks, diet soft drinks, and ready-to-drink iced tea. The spending by the black population and the Spanish-speaking population is above the average of 100. So black and Spanish-speaking consumers tend to overspend on regular carbonated soft drinks. Conversely, they are underspending, compared to whites, on diet soft drinks. If you look at the ready-to-drink iced tea category, once again, they are overspending. In most of the sweet categories and cakes, you will see the same type of pattern.

Once they notice that consumers are ready to spend their money on these products, marketers will say, "Where should I be spending my money to reach these consumers?" Some of the studies that we have been looking at examine targeted media, say, for instance, in magazines such as *Ebony, Jet, Black Enterprise, Vibe, Source,* and *Essence*. Then we compare the media expenditures in food and beverage categories and sugared products, compared to mainstream magazines such as *Time* or *Newsweek*.

If you look at the readership of these media and compare the diet soft drink versus regular carbonated soft drink advertisements, magazines targeted to African Americans tend to have a higher percentage of readers who consume regular carbonated soft drinks compared to the readers of *Business Week* and *People*. It is just a flip-flop for diet soft drinks.

Let us turn to BET, Black Entertainment Television. I looked at some of the top advertisers on BET. The top 50 advertisers, such as General Mills, Pepsi, McDonald's, Coca-Cola, are right up there in the top 10. If you look at the actual brands as opposed to the parent company, once again, you will see companies in the top of BET advertising—McDonald's, Pepsi, Coke, Wendy's, Domino's, and some of the others that are all targeted towards food and beverage categories.

One of the things that we have done is to look at other ways that marketers try to reach out to minority consumers with their marketing messages in terms of food. We took the top 100 grossing films for two years, and we did a content analysis to see what the movie food pyramid guide would look like compared to the regular food pyramid guide. In addition, we looked at foods and movies that were targeted

Even for an educated parent, feeding your child well these days can be difficult.

towards minority consumers. When we got to those kinds of movies, it was interesting to see the overabundance of things such as malt liquor and junk food. Sometimes it is product placement in which a camera angle really focuses on a product such as Coca-Cola.

I just want to sum up with work being done by some other researchers. One study looked at TV ads in prime time. The researchers compared the ads on prime time television to ads that are on what they call black prime time—that is, those programs that are primarily viewed by African-American audiences during prime time. The researchers concluded that more food commercials are aired during black prime time than general prime time. They also found out that 30 percent of the food commercials featured candy, and 13 percent featured soda, significantly more than on general prime time.

Finally, the key question is to what degree can you leverage pressure on the food and beverage industry in terms of influencing their advertising versus getting more bang for the buck and convincing consumers to change their preferences for certain kinds of food. That is really the issue.

Margo Wootan, Center for Science in the Public Interest

There are many different contributors to childhood obesity. It is a complex condition with multiple contributors, including both nutrition and physical activity. Food marketing is a key and very important contributor.

It has become increasingly difficult for parents to feed their children well. Parents can model healthy eating. They can encourage their children to eat better. But they are totally outmaneuvered and outgunned by the restaurant and other food industries that have slick and sophisticated techniques to encourage children to eat the very foods that parents would like their children to eat less of. Parents do not have Sponge Bob or sports stars or contests that they can use at the dinner table each night. Even for an educated parent, feeding your child well these days can be difficult.

It is not that marketing is really the problem. I would not mind if Sponge Bob was used to sell carrots. But the fact is that food companies are not marketing bananas and broccoli to children. Virtually all of the foods that are being marketed to children are unhealthy foods. So it is not only that they are marketing very aggressively, but they are marketing mostly low-nutrition, high-calorie, high-sodium foods, that are high in saturated fat and other problem nutrients.

Kids these days are exposed to such a tremendous amount of marketing for those foods that they want those foods very much. They are asking their parents, and it is difficult for parents to keep saying no, no, no, all the time.

My role today is to talk about what we can do about this. Our food environment is so out of whack, there is so much money, and so many unhealthy choices available. Those unhealthy choices are marketed so aggressively. Is there anything that we can do?

The issue of food marketing is not a new one, though the problem has become worse and the amount of marketing has doubled in just the last 10 years. People were concerned back in the 1970s about marketing. At that time, parents and advocates were especially concerned about the marketing of sugary foods to children, which were probably the foods that were most heavily promoted. So in 1978, the Federal Trade Commission (FTC), after doing a review and a big study, made some strong recommendations about food marketing aimed at children. They recommended a ban on all advertising aimed at young children. They recommended that sugary foods not be marketed to older children, and they also recommended that food companies and advertising agencies kick in funding for campaigns and marketing to encourage children to consume healthy foods.

As you might imagine, food companies and marketers were not very happy with the conclusions of the Federal Trade Commission, and so they went to their friends in Congress to ask for help. Congress very readily agreed to help out their supporters, and in 1980 the Congress passed the Federal Trade Commission Improvement Act, which most people in the health field believe did not do anything to improve the Federal Trade Commission. It actually stripped the Federal Trade Commission of all authority to take any kind of broad regulatory action around the issue of food marketing. It has left the FTC, to this day, with only the ability to look at marketing aimed at children, including food marketing, on a case-by-case basis. So these days, the regulation of food marketing aimed at children is left mostly to the occasional case-by-case enforcement actions that the Federal Trade Commission takes.

It is also left to self-regulation. Those industries that have a financial interest in selling food to children are regulating themselves about food marketing, primarily through the Children's Advertising Review Unit, or CARU. CARU has an advisory board that includes many of the largest food companies. Its goals are not ones that anyone in the health field would disagree with. The goals are quite sound, but they are written in such a vague way that they would be difficult to enforce even if enforcement was taken. When cases do come before either the FTC or CARU, an ad campaign already has run its course, and a food company does not mind taking it off the air because they were about to take it off the air anyway.

Those industries that have a financial interest in selling food to children are regulating themselves.

Overall, case-by-case enforcement is not ever going to be an effective way of addressing food marketing aimed at children, partly because there is so much advertising out there, and to take action against all these ads would be very difficult. Even so, it does not take into consideration the kinds of foods that are being marketed. It really has to do more with how the pitch is made. With some of these unhealthy foods, even if you change the form, such as using a toy giveaway, a contest, or a cartoon character, it is not going to much matter, because most of the food that is marketed is unhealthy.

Now, in contrast to how things are regulated here in the United States, in other countries there are much stronger regulations for marketing aimed at children. In a number of countries, there is no advertising allowed at all. In Sweden, in Norway, in the Flemish region of Belgium, in Quebec, Canada, there are bans on advertising aimed at young children. They each define the age of children a little differently, but it is often around the age of 12 or 13 years. In other countries, such as Austria, Belgium, Germany, and Portugal, no marketing is allowed in schools.

In the United States, we do have regulations related to other health behaviors or other products that affect children's health. There are no advertisements allowed for cigarettes and smokeless tobacco products on television or on radio, by federal law. Also, there are limits on the age at which children are allowed to buy tobacco products.

Action can be taken on different fronts, depending on what you want to change. For changing television advertising, the only way to do that is at the federal level, because that is where television advertising is regulated.

Congress could give authority to the Federal Trade Commission to work with the U.S. Department of Health and Human Services to develop nutrition standards for the kinds of ads that can and cannot be advertised to children. There could be limits on the kinds of foods that are marketed to children on television and through magazines.

At the state or the local level, there could be limits on marketing in schools. School districts could put into place a policy, or states could pass laws to limit the marketing of unhealthy foods aimed at children.

Now, those things are probably going to take some time, and there is not quite the political will to move on this issue right away. In the meantime, at the local level, communities could come together—health professionals, parents, foundations, elected officials—to try to call on companies to market food more responsibly to children. Those guidelines might regulate the kinds of marketing techniques that can and cannot be used, the kinds of foods that should and should not be marketed to children, and encourage companies not to show huge portion sizes or to use cartoon characters to sell junk food to children. The Center for Science in the Public Interest is developing guidelines for responsible food marketing aimed at children, and those should be available this spring. These guidelines can be used for letter-writing campaigns and for publicity that would put pressure on food companies to change their practices.

We have pulled together a new resource on food marketing aimed at children that outlines the types of marketing techniques used, the kinds of products that are marketed, the effect that it has on children's diets, what can be done about it, what is being done in other countries.

Companies want to make sure that everywhere children are, their products are. So if a child has even the slightest inkling to get that product, it will be right there. Everywhere you go there are opportunities to eat. At shopping malls, at highway rest stops, at bus stations, at airports, there are outlets for fast food and convenience-like stores. It did not used to be that you could get food at a gas station.

A key place where companies are trying to place their products is in schools. The availability of snack foods and soft drinks in schools is a key goal of many soft drink and snack food companies. The problem is the products that are getting placed are not healthy. So one key way to address food marketing is to improve the nutritional quality of the foods that are offered in schools. Get the soda and the candy out of the vending machines, the a la carte lines, the school stores, and the fundraisers.

One key way to address food marketing is to improve the nutritional quality of the foods that are offered in schools.

It just does not make sense to fund our schools at the expense of our children's health. You know, in the long run, we are sure to spend a lot more money on the diet-related diseases that will result from this lack of regulation than we could ever hope to make selling soda pop and other low-nutrition foods in schools. This action could be taken at the federal level, at the local level, or at the state level.

We do not need to get rid of the vending machines. We just need to improve the offerings that are in those machines. Nutrition standards that have been developed could be put into place at any of these levels. The Center for Science in the Public Interest has another resource, a tool kit, that might be useful to people who are trying to improve the nutritional quality and reduce marketing of unhealthy foods in schools. The tool kit has background materials and model policies, model legislation, model school board testimony, and other resources that people would need to make changes in their school foods.

Another key tool of marketers is price. We know portion sizes have gotten really big in restaurants and in the grocery stores. But what people do not realize is that foods are often priced to make these big portion sizes irresistible. A study that was done about a year and a half ago by the National Alliance for Nutrition and Activity found that for just a little more money you could upgrade from the small to the medium or the medium to the large or the large to the super size. It seems like such a bargain. Why not get the double gulp, instead of the gulp? Teenagers feel as if they are getting ripped off if they get the small size, because for just a little more money you can upgrade. But what they do not realize is that they are getting a lot more calories. It could result in 450 more calories just by upgrading from the smallest size to the biggest size. That is a quarter pounder's worth of calories.

Big portion sizes are especially a problem in restaurants. Value marketing has been extremely profitable for the restaurant industry, to the point where super sizing something is now a verb. It is not uncommon for an appetizer to have a half a day's calories, for entrees at restaurants to provide 1,000 calories, which is about a half a day's worth or more for most people. If you add a side dish, or an appetizer, or a dessert, you could easily eat a whole day's worth of calories in a single sitting.

We just did a study this week looking at children's menus and found that virtually all of the choices are unhealthy ones. You are lucky if you can find one healthy entree on the children's menu, and that it is very common for the meals at children's restaurants to provide 600 to 1,000 calories, which is more than a half a day's worth for a young child. Sometimes the menu will indicate that you can substitute, but the default option is the unhealthy one.

Parents cannot tell what they are actually feeding their children because there isn't any nutrition information on the menu. Two-thirds of the largest chain restaurants, not small Mom-and-Pop type restaurants, but the big chains, do not provide a single shred of nutrition information to their customers anywhere. If you look at the third of restaurants that do provide nutrition information, most often it is on a Web site, which means you have to log on to the Internet, figure out what you and your children are going to eat before you leave home. Occasionally, the largest fast food chain restaurants will have a poster or a brochure, something in the restaurant, but those also can be very hard to find, difficult to read. You have to leave your place in line, track this thing down, and it can take five or 10 minutes. You can imagine with your kids in tow.

The one thing that these posters and brochures and Web sites do show, though, is that these companies have these numbers and can provide this nutrition information. If they can put these numbers on a Web site or a poster, they should be able to put those numbers on a menu or a menu board where it would actually help someone. Restaurant foods are important because people are eating out twice as often as they did in 1970. Now children get about a third of their calories from away-from-home foods, from restaurants and other similar food service establishments.

One way to deal with this is for localities, states, or Congress to pass a law that would require calorie and other nutrition labeling right on the menu or the menu board where it is easy to find, easy to see, and easy to use. Right now you would never think of ordering at a fast food restaurant without seeing the price. Why not also be given the price in terms of your health?

Right now you would never think of ordering at a fast food restaurant without seeing the price. Why not also be given the price in terms of your health?

I have talked about a number of different policy options. I know that many foundations shy away from funding policy for fear of funding lobbying. But advocacy is what is most needed around the issues of nutrition and physical activity. We must get away from focusing so much on just education. We have lots of pamphlets and posters and curricula and *5 A Day* bingo, and other kinds of educational tools. It is not going to be enough.

Just given the environment that we live in with food everywhere served in huge portions, marketed aggressively, and the lack of nutrition information in many places, we must change the food environment around us to make it easier for people to eat better.

Lobbying is a small part of this advocacy to change policy, to change the food environment. You know, I am a full-time advocate, but I probably only spend about 10 percent of my time lobbying. Most of it is getting other organizations to support us, building public support, providing strategic or technical advice, writing background documents and fact sheets, developing the policies, and working with the press. Lobbying is only a very small part of it.

I will end by pointing out two other resources available from the Center for Science in the Public Interest. One is our Web site on policy for nutrition and physical activity, which has more information about the policies I spoke of earlier—http://cspinet.org/nutritionpolicy/index.html. The final resource is a Web site that we have for middle-school age children, which teaches them that there are many influences on their eating habits and some ways of dealing with them—http://www.cspinet.org/smartmouth/index1.html. This helps them to understand that somebody cares about what they eat, but mostly from the standpoint of wanting to sell them more food. It helps kids better understand what some of those influences are to give them a better chance at eating well.

Remarks on Accepting 2004 Terrence Keenan Leadership Award in Health Philanthropy

David A. Gould, United Hospital Fund

I am truly honored to receive the Terrence Keenan Leadership Award. I think I may be the first person to receive this award who did not have the benefit of working directly with—and learning from—one the most respected leaders and pioneers in health care philanthropy. Yet I believe that the values Terry Keenan has championed so well have become embedded in the best of health care grantmaking:

- a conviction that change is necessary and that it is possible;
- the understanding that change requires hard, and often selfless, work;
- a belief in the benefits of partnership and collaboration—among foundations and between foundations and grantees;
- a willingness to take risks, combined with the need to thoughtfully manage those risks; and
- an unwavering commitment to the grantee.

In accepting this award, I want to try to offer—with all due modesty—a few thoughts on how we can continue to carry on with the challenge Terry Keenan—by his example and teaching—has set for us as grantmakers in health.

I will also try to do this as briefly as possible. But before tackling this assignment, I have to speak directly to the issue that while the award is made to an individual, anyone lucky enough to receive the honor understands full well that his or her accomplishments are the products of many. I need to—and want to—recognize two clusters of persons who share this honor with me today, and who honor me with their presence.

First is my family. My wife, three daughters, and one son-in-law have trekked from Boston, New York, and San Francisco to enjoy this event, and purely by coincidence to endure the hardships of Florida in February. It is a thrill to look down and see them together. I am smart enough not to try to publicly thank my wife for all that she has done over the past 35 years. So, let me say something about my kids. They honor me by being here, but, more importantly, they truly honor me every day by living their lives with such principle, passion, and purposeful adventure. If we are here to build a better future, they give me real optimism.

Second is my nuclear professional family for the past 18 years—the people of the United Hospital Fund. It is really the fund, in all its complexity, with all its moving parts, that has “earned” the Keenan Award. So I want to take a few moments to explain the fund, which has given me so much opportunity and so much support.

The fund is an independent, 125-year-old public charity whose mission is to make positive change in New York's health care. Over these years, the fund has developed a pretty diverse tool box. It does grantmaking to foster innovation and launch model programs in all parts of the health care system, not just hospitals; just what you might expect of a foundation. But the fund is also a small but active center for health services research and cutting-edge policy analysis. These activities help us better understand where and how we should target our grantmaking, and where we can productively engage in the debate over the future of our health care system.

And the fund is committed to sharing what we learn and what we believe. Through our publications, Web site, conferences, and invitational meetings and forums, we try hard to bring objective information to the challenge of improving the organization and financing health care services.

That being said, the fund is a small organization in a big city whose health care system has both unparalleled problems and unequaled resources. So, we seldom work alone. A spirit of genuine partnership suffuses and energizes our work, both within the fund and with what I call our "coconspirators for change."

First, within the fund: we are governed by a board of directors that has displayed a remarkable ability to focus on what is important. First has been its steadfastness, during some pretty turbulent times, in adopting and implementing a strategy dedicated to promoting change in a health care system that sorely needs it.

Perhaps most important, the board has selected two extraordinary individuals to lead the fund over the past 20 years—Jim Tallon and Bruce Vladeck. Those of you who know them can easily understand my delight in partnering with them to reshape a venerable organization. All of our work at the fund has been guided by their principled vision of what a health care system ought to be and by their strategic sense of how to make real and sustained change.

We often hear about "standing on the shoulders of giants." And, despite Jim and Bruce's notable stature, when I use this phrase in the context of the fund, I think not so much of them as I do the band of remarkable thinkers, doers, and activists who have worked so closely with me over the years to create the fund's program. Among the "giants" who are not formally recognized here today are folks like Carol Levine, who directs the fund's *Families and Health Care Project*, and whose genius has shaped the fund's pioneering activities to support family caregivers. And Kathryn Haslanger, our vice president for policy analysis, whose intellect and passion have driven so much of our work with the issues of the uninsured, Medicaid, and primary care, as well as our success in enrolling 340,000 New Yorkers in Medicaid in the months after September 11th. To say it's a privilege to collaborate with them—and with many other colleagues who go without mention today—doesn't even begin to capture the mix of excitement, dogged persistence, and mutual support that characterizes our work together.

Because the Keenan Award recognizes me, and the fund, as a grantmaker, I want to separately recognize Debbie Halper—who has diligently guided and managed all of our grant programs for 16 years. Debbie not only has helped to set strategy and design major initiatives, her skill in working with multiple grantees and several concurrent program initiatives makes all the difference between flashy promises and productive innovation.

The fund's effectiveness as a grantmaker also rests heavily on our ability to partner with our merry band of "coconspirators," by providing grant support and program guidance. Without the vision, dedication, and hard work of these leaders in health care and social services, we wouldn't have much of an outlet for our philanthropy. It's always frustrating to cite but a few examples. But to give you a sense of our partners I'll mention:

- Nancy Dubler, a lawyer at the Montefiore Medical Center, who with grant support from the fund has created model training programs and has written two major fund publications on mediation and bioethics;
- Rick Surpin, who used grants from the fund to help create the nation's first worker-owned home care company, and whose participation has been critical to several fund projects analyzing long term care;
- Denise Rosario, a child welfare leader, who brought primary care services to a Latino community in Bushwick, and Neil Calman, a family practice physician, who did the same in partnership with housing development companies in the South Bronx—both working with grants from the fund's *Primary Care Development Program*, which was itself funded by a consortium of national and New York City foundations;
- Henry Chung, who as medical director of the Chinatown Health Clinic secured fund grants to design and test a blended model of mental health and primary care services in New York's Chinatown, where it was said it couldn't be done but whose success has led to a national program; and
- Maggie Hoffman, who used fund grants to bring *Project DOCC*, an exciting parent-led pediatric residency training program, to eight New York City hospitals and to another 18 medical centers across the country.

I could go on, but these few examples illustrate what I mean when I say the fund is only as good as its partners.

As I thought about what I wanted to say to you today, I was—and still am—daunted by the notion of speaking to a group of grantmakers with so much experience and savvy. This is no easy task. So, perhaps I should begin by explaining where I'm coming from by describing three cartoons pinned to the wall in my office at the fund.

The first is evidence of a certain sense of fatalism entwined with blind faith that good will ultimately prevail. It's a *New Yorker* cartoon of a rumpled middle-aged man stretched out on a shrink's couch. He's wearing a Boston Red Sox hat and sweatshirt, and the caption speaks the psychiatrist's consolation: "Rooting for them is a disease, David. It's nothing to be ashamed of." So, I present myself as a die-hard Red Sox fan, and it's fair for you to dismiss all further comments as the musings of a demented soul who is impervious to 86 consecutive years of failure.

The second cartoon, also from the *New Yorker*, is one of my favorites for its insight and ambiguity. It shows a beaver and a rabbit looking up at the spillway of an enormous dam. The beaver proudly explains: "I didn't actually build it, but it was based on my idea." This so wonderfully captures the interplay between concept and execution, between the individual idea and the collective effort required to take elegant concepts and execute them into reality. The beaver may be partly right, but he's mainly delusional.

The third cartoon cuts to the core of a good deal of my professional day. It shows a mother and young child looking into the office where a frazzled man sits fixated before his computer screen. The mother explains: "Daddy can't come and play, until he finishes his proposal."

I mention this last cartoon to confess to the schizoid reality of my professional life: I am as much a grant seeker as I am a grantmaker. Much of the work of the fund since 1985 has involved braiding our ability to make grants to support innovation with our need to secure grants to bring additional staff expertise to the fund. So as I look around this room, I see many of the fund's foundation partners that have made so much of our work possible, and thank them for their support.

Because Terry Keenan has written so cogently about the responsibilities of grantmakers, what I have to say is really commentary on the master's text. But I'd like to think that my duality, this twinned perspective of grantmaker and grant seeker, perhaps will enable me to offer a few fresh observations.

But first I need to provide a bit more context. Whatever instruction my work as a grantmaker with the fund may offer, it stems from my experience in what is effectively a small foundation, making a reasonable number of modest grants in a local area. We are not a national foundation with tens or hundreds of million dollars to spend annually. And however large and daunting New York City may appear, it is not the U.S. Because we act locally, we have a real opportunity to learn about and learn with our potential and actual grantees. So, at the risk of sounding like a small-town guy who lived in a simpler time, I want to make a few points that I believe have relevance to all grantmakers.

Let me start with a farming metaphor commonly found in grantmaker literature—the notion of "seed money" or "seed grants." I don't want to make too much of words, but metaphors matter. And, I think, this one is misleading. If by seeds we mean the ideas and concepts that will drive change in the near term, and from which our future health care system will grow in the longer term, then I believe it is important that foundation staff should not expect to be the major source of creative and innovative ideas. We shouldn't see grants as the way we help others to buy our seeds, to implement our beautiful ideas, to build out our elegant blueprints.

Instead, to be creative and generative grantmakers, we need to seek out, challenge, and then support champions for change working in the trenches: clinical professionals, planners and analysts, administrators, academics, patients and their families. These are the people who best understand what's wrong with health care and what would make it better.

At the fund, we try hard to articulate our commitment to an issue in a way that engages these change leaders. Our work with palliative care is a good example. Here our early concern, expressed through the launch of a major grant initiative, helped legitimize the issue in New York, putting it on the agenda of health care organizations across the city. In turn, this energized local champions and helped direct significant resources to their work to understand the problem and craft solutions.

The fund's ability to bring focus to an issue—to set a strategic goal or direction—really matters. It translates our broad mission statement into defined action. But, what we don't do is prescribe the intervention. We set some parameters, but we look to the change champions to identify and then test how to improve the delivery of care in the idiosyncratic context of their own organizations. As grantmakers, we don't assume we have the answer—we hope we have the right question.

As a grant recipient, I think the fund and its supporting foundations have been most productive when we, too, were encouraged to be creative risk takers. Sticking to the case of palliative care, it was Kathy Foley's gutsy commitment of a major grant from the Project on Death in America (PDIA) that helped launch our multiyear, multihospital initiative. In response to a brief proposal, PDIA asked some challenging questions that probed our principles and sharpened our priorities. But then PDIA gave us the latitude to get to work and see where our skills and experience would take us.

My second point is that grantmakers should spend more effort on helping grantees tackle their challenges and advance their work. I don't want to suggest that we do the work that our grantees are far better prepared to take on. It's a fine line between being helpful and being intrusive, meddlesome, and a micromanager. Nevertheless, I think we devote too much effort to the front door—to awarding grants—and too little on learning from and assisting our grantees.

As a grantmaker in New York City, and as an organization with considerable analytic resources and convening capacity, the fund has tried with some success to play this role. Early on, we were struck by how isolated our grantees were from one another—even though they lived and worked in the same city. So we made a concerted effort to regularly convene small groups of grantees that were tackling similar or complementary issues. Together, we were able to foster a sense of community, to share ideas and expertise, to solve some common problems, and to identify new ones.

If this work is akin to the cultivation stage of the farming metaphor so often applied to grantmaking, it is also important to say a few words about the harvesting phase. Here I think we all could do better at working with grantees to share what they have learned. Not surprisingly, many of the most creative agents of change in their own organizations either don't pay much attention to dissemination or they are not very good at it. They need encouragement and assistance to extract and share the most valuable lessons they have learned.

Here, foundations, which often have well-honed communications skills, can help and can add real value to the change process. Actions may speak louder than words, but without the words or the video, too many valuable accomplishments will remain best kept secrets, not shared best practices. Furthermore, by nurturing a more effective dissemination strategy for its grantees, a foundation will become more effective in clarifying its own priorities and setting its agenda.

Having said that my experience as a grantee would color my comments, I have to observe that I should be careful what I ask for. It is easy for me to recall experiences with foundations that range from the extremes of benign neglect to quite bothersome meddling. Yes, finding the right balance between hands off and helping hands is hard. But this cannot excuse grantmakers from developing a consistent approach to working more effectively in partnership with their grantees.

Despite my sincere efforts, I don't think I have suggested any actions or practices that many of you haven't already thought about and put to the test. But in closing, I want to raise a note of concern. Much of grantmaking today demonstrates a powerful attraction to a business model. We read of strategic investment policies, balanced portfolios, carefully calibrated financing models for self-sustainability, projection of return on investment, and the like. I fear that the seductiveness of an approach that has generated the wealth that foundations have at their disposal may well distract us from—and even devalue—what can be the distinctive and invaluable contribution of foundations.

Foundation leaders are rightly concerned with effectiveness and accountability. But these real needs should not translate into a single focus on realizing short-term, easily measured gains; it should not undermine the commitment to supporting high-risk ventures; it should not lead us to support only modest, incremental programs with a high probability of sustainability at the risk of failing to nurture the visionaries whose work won't generate sound-bite media attention.

As much as foundations want to be a part of the mainstream—because they correctly see it as a means to be influential—they also have the capacity to stand apart and counter some of the least desirable aspects of modern life: our society's disdain for the past, its sense of breathless, impatient urgency, and its continuing ambivalence about local and global perspectives. Foundations have the luxury of not having to satisfy stockholders, voters, or consumers in the next quarter, election, or product launch. Let's be certain that we make the most of this potential to tackle the pivotal issues that will shape our society with the independence, freedom to take risks, and constancy that Terry Keenan would expect of us.

Thank you.

Speaker Profiles

King Davis

King Davis is executive director of the Hogg Foundation for Mental Health and the Robert Lee Sutherland Chair in Mental Health and Social Policy in the School of Social Work at The University of Texas at Austin. Prior to coming to the foundation, Dr. Davis was a professor of public mental health policy and planning at the Virginia Commonwealth University, and earlier held the William and Camille Cosby Chair at Howard University. He has also served as the Libra Chair in the School of Business and Public Policy at the University of Maine, and was a distinguished visiting professor at Washington University in St. Louis. Dr. Davis was appointed by Virginia Governor Doug Wilder as a commissioner of the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, where he was responsible for executive leadership and management of a statewide behavioral health care system comprised of 17 hospital facilities and 40 community service agencies with an annual budget of $700 million and 17,000 staff. Dr. Davis has also held full professorships at each of Virginia's three medical schools and departments of psychiatry as Galt Visiting Scholar. He has received the Excellence in Teaching Award from The University of Texas at Austin and the lifetime achievement award from the Council on Social Work Education. Dr. Davis received his bachelor's and master's degrees in social work from California State University, and received his doctoral degree from the Florence G. Heller School for Social Policy and Management at Brandeis University.

Harvey V. Fineberg

Harvey Fineberg is president of the Institute of Medicine. He served as provost of Harvard University from 1997 to 2001, following 13 years as dean of the Harvard School of Public Health. He has devoted most of his academic career to the fields of health policy and medical decisionmaking. His past research has focused on the process of policy development and implementation, assessment of medical technology, evaluation and use of vaccines, and dissemination of medical innovations. Dr. Fineberg helped found and served as president of the Society for Medical Decision Making and also served as consultant to the World Health Organization. At the Institute of Medicine, he has chaired and served on a number of panels dealing with health policy issues, ranging from AIDS to new medical technology. He also served as a member of the Public Health Council of Massachusetts, as chairman of the Health Care Technology Study Section of the National Center for Health Services Research, and as president of the Association of Schools of Public Health. Dr. Fineberg has coauthored and edited several books on diverse topics such as AIDS prevention, vaccine safety, and understanding risk in society. He has also authored numerous articles published in professional journals. He received the Joseph W. Mountain Prize from the Centers for Disease Control and Prevention, and the Wade Hampton Frost Prize from the Epidemiology Section of the American Public Health Association. Dr. Fineberg earned his bachelor's and doctoral degrees from Harvard University.

David A. Gould

As vice president of program at the United Hospital Fund, David Gould is responsible for program development and grantmaking activities. His leadership has led to the successful development of several fund initiatives, including the *Primary Care Development Program*, the *Palliative Care Initiative*, the *Families and Health Care Project*, and the *Aging in Place Initiative*. The success of these multifaceted programs is grounded in Mr. Gould's insights into the complexities of New York City's health care system, his ability to identify emerging issues, and his reputation for bold and aggressive responses to the most intransigent of problems. Prior to joining the fund, Mr. Gould held positions with the Department of City Planning of the City of New York and the Vera Institute on Justice. Mr. Gould currently chairs the grantmaking committee of the New York City AIDS Fund, chairs the National Advisory Committee of the Center to Advance Palliative Care, serves on the board of the Primary Care Development Corporation, and is a member of several committees advising the government and private agencies on issues relating to health care policy.

Pedro Jose Greer, Jr.

Joe Greer is assistant dean at the University of Miami School of Medicine and chief of gastroenterology at Mercy Hospital. Dr. Greer's concern for those without access to health care has fueled his passion to create various free clinics for the homeless, undocumented, migrant, and poor of Miami. As a medical intern, he founded and continues to be the volunteer medical director of Camillus Health Concern, which now serves over 10,000 homeless patients a year. He has been an advisor to both the Clinton and Bush, Sr. Administrations. His articles and book chapters range from digestive disorders to issues of policy and poverty in America, and he has been featured frequently in the national media. Among Dr. Greer's many honors have been the MacArthur Foundation Fellowship and the Presidential Service Award. He was also named by *Time* magazine as one of America's 50 young American leaders under 40, Doctor of the Year by the magazine *Hippocrates: Health and Medicine for Physicians*, and Hispanic of the Year by *Hispanic Magazine*. He is currently a trustee at the RAND Corporation; a board member at the Mellon-United Bank of Florida; and chairman of the Hispanic Heritage Awards Foundation, Comic Relief, and other national organizations. He has also served on the boards of Dr. Pepper/7-UP, Physicians for Human Rights, and The Cuban-American National Council. Dr. Greer holds a bachelor's degree from the University of Florida; attended medical school at La Universidad Catolica Madre and Maestra; and completed his residency training at the University of Miami, where he was chief medical resident and a fellow in hepatology and gastroenterology.

Lauren LeRoy

Lauren LeRoy is president and CEO of Grantmakers In Health (GIH). Before joining GIH, Dr. LeRoy was executive director of the Medicare Payment Advisory Commission (MedPAC), a nonpartisan congressional advisory body. Prior to MedPAC, she served as executive director of the Physician Payment Review Commission (PPRC). She came to PPRC in 1986 from The Commonwealth Fund

Commission on Elderly People Living Alone, where she served as associate director. Dr. LeRoy spent more than a decade at the Institute for Health Policy Studies, University of California, San Francisco, where she was assistant director and managed the institute's Washington office. She began her career as an analyst working on health issues in the U.S. Department of Health, Education, and Welfare. Dr. LeRoy's research interests and published works have focused on Medicare reform, the health workforce, health care for the elderly, reproductive health, and health philanthropy. She is a member of the National Academy of Social Insurance and a fellow of AcademyHealth. In 2000, she chaired the Institute of Medicine (IOM) Committee on Medicare Payment Methodology for Clinical Laboratory Services, which produced the report, *Medicare Laboratory Payment Policy: Now and in the Future*. She also chaired IOM's Committee on Public Financing and Delivery of HIV Care, which produced the report *Public Finance and Delivery of HIV/AIDS Care*. She is a senior fellow at the UCLA School of Public Policy and Social Research and sits on the board of senior advisors of the Center for Advancing Community Health, the national board of advisors of the Iris Alliance Fund, and the University of California, Berkeley School of Public Health dean's policy advisory council. She received a doctorate in social policy planning from the University of California, Berkeley.

Marion Standish

Marion Standish is the director of programs with The California Endowment. In addition to her work reviewing and recommending grants, Ms. Standish has been the endowment's lead officer on two major funding initiatives. The *Partnership for the Public's Health* is a five-year program designed to build strong, effective partnerships between local public health departments and the communities they serve. In addition, she designed and directed The California Endowment's partnership project with The Rockefeller Foundation. *California Works for Better Health* is a four-year jointly designed, funded, and managed initiative to build the capacity of community-based organizations to improve neighborhood health status through regional employment strategies. Prior to joining the endowment, Ms. Standish was founder and director of California Food Policy Advocates (CFPA), a statewide nutrition and health research and advocacy organization focusing on access to nutritious food for low-income families. Before launching CFPA, she was director of California Rural Legal Assistance Foundation, a statewide advocacy organization focusing on health, education, and labor issues facing farm workers and the rural poor. She began her career as a staff attorney with California Rural Legal Assistance, a federally funded legal services program. Ms. Standish serves on the board of directors of the Food Research and Action Center and the San Francisco Community Boards Program. She was recently appointed to the San Francisco Workforce Investment Board. Ms. Standish received her J.D. from the University of San Francisco School of Law and undergraduate and graduate degrees from New York University.

Mary Story

Mary Story is a professor in the division of epidemiology and associate dean of student affairs in the School of Public Health at the University of Minnesota. She is also an adjunct professor in the department of pediatrics at the University of Minnesota School of Medicine, where she is on the faculty in the adolescent health program. Dr. Story holds a doctorate in nutrition sciences and has worked in the area of child and adolescent nutrition for several years. Her research focuses on understanding factors related to eating behaviors of youth; and community- and school-based interventions for obesity prevention, healthy eating, and physical activity. She has authored over 200 scientific journal articles and book chapters in the area of child and adolescent nutrition. She has received several awards for her work with children and adolescents. She is the immediate past chair of the Food and Nutrition Section of the American Public Health Association.

Jerome D. Williams

Jerome Williams is the F.J. Heyne Centennial Professor in Communication in the Department of Advertising at the University of Texas at Austin. He also holds a joint appointment in the Center for African and African American Studies. Previously, he served on the faculty in the marketing departments at Pennsylvania State University and in the business school at Howard University, where he was also director of the Center for Marketplace Diversity. He conducts research in a number of consumer marketing domains, with emphasis on multicultural marketing. He has testified in a number of court cases as an expert witness on consumer response to advertising strategies. He has published extensively on multicultural marketing, and he is coeditor of a book on diversity in advertising and coauthor of a forthcoming book on consumer racial profiling.

Margo Wootan

Margo Wootan is the director of nutrition policy at the Center for Science in the Public Interest, one of the country's leading consumer advocacy organizations that specializes in food, nutrition, and public health issues. She also serves as the director of its *1% Or Less* campaign, a community-based nutrition promotion program, and leads the efforts to require trans fat labeling. Dr. Wootan cofounded and coordinates the activities of the National Alliance for Nutrition and Activity, a coalition of more than 240 national, state, and local organizations. Dr. Wootan is quoted regularly in the media on subjects ranging from obesity and trans fat to school lunches, has published scholarly papers in the areas of nutrition education and fatty acid transport and metabolism, and has testified before the U.S. Congress and spoken before federal and state agencies. She is a member of the National 5-A-Day Partnership steering committee and cochairs its policy subcommittee. Dr. Wootan has been recognized for her outstanding leadership and dedicated service and won awards from the American Public Health Association, Association of State and Territorial Public Health Nutrition Directors, the Society for Nutrition Education, and the Society for Prevention Research, as well as the National Health Information Award. Dr. Wootan received her bachelor's degree in nutrition from Cornell University and her doctorate in nutrition from Harvard University's School of Public Health.

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